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In re Application of: Haim AVIV et al.

Confirmation No. 6729

Application No.: 10/644,687

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Examiner:

**For: HIGH ENANTIOMERIC PURITY
DEXANABINOL FOR PHARMACEUTICAL
COMPOSITIONS**

Attorney Docket No.: 87754-7500

SUBMISSION OF CERTIFIED PRIORITY DOCUMENT

Commissioner for Patents
P.O. Box 1450
Alexandria, Virginia 22313-1450

Sir:

Applicants have claimed priority under 35 U.S.C. § 119 of Application No. IL 153277 filed December 4, 2002 in Israel. In support of this claim, a certified copy of said application is submitted herewith.

No fee or certification is believed to be due for this submission. Should any fees be required, however, please charge such fees to Winston & Strawn LLP Deposit Account No. 50-1814.

Respectfully submitted,

Date: 11/4/03

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Enclosures

לשימוש הלשכה
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153277

מספר:
NUMBER

תאריך:
Date

04 -12- 2002

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ANTE/POST-DATE

בקשה לפטנט
Application For Patent

אני, (שם המבוקש, מענו ולגבי גוף מאוגז – מקום ההתקשרות)
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בעל אמצעה מכח By Law and Assignment

הדין והנברה
הוא

of an invention, the title of which is

Owner, by virtue of

דקסאניבינול בדרגת ניקיון אננטיומרי גבוה
להכנות תכשירים פרטיצטיטים

(בעברית)
(Hebrew)

HIGH ENANTIOMERIC PURITY DEXANABINOL FOR
PHARMACEUTICAL COMPOSITIONS

(באנגלית)
(English)

hereby apply for a patent to be granted to me in respect thereof.

מבקש בזאת כי ינתן לי עליה פטנט

*בקשה הלווה- Division of Application	*בקשה פטנט מוסף- Addition Application for Patent	*דרישה דין קדימה Priority Claim		
מבקש פטנט Application from No..... dated..... מס... מיום..... מיום.....	בקשה לפטנט to Patent/Application No..... dated..... מס... מיום..... מיום.....	מספר / סימן Number / Mark	תאריך Date	מדינת האגד Convention Country
P.O.A.: general filed in case 147941	*יבו כה: כלל הוגש בעניין			
PRS2/016 IL	המען למסירת מסמכים בישראל Address for service in Israel			
Webb & Associates Patent Attorneys P.O.Box 218 Rehovot 7612	ובשות' עורכי פטנטים ת.ד. 2189 רחובות 76121			
For the Applica Cynthia A. Patent Attorney	חתימת המבוקש Signature of Applicant	היום 3 בחודש דצמבר שנת 2002 This 3 of December of the year 2002		לשימוש הלשכה For Office Use

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which are set out above

**דקסאנabinול בדרגת ניקיון אנאנטיומרי גבוהה
להכנת תכשירים פרמצבטיים**

**HIGH ENANTIOMERIC PURITY DEXANABINOL
FOR PHARMACEUTICAL COMPOSITIONS**

PRS2/016 IL

HIGH ENANTIOMERIC PURITY DEXANABINOL
FOR PHARMACEUTICAL COMPOSITIONS

FIELD OF THE INVENTION

5 The present invention relates to a synthetic cannabinoid, dexanabinol, of high enantiomeric purity, to pharmaceutical grade compositions comprising it, and uses thereof.

BACKGROUND OF THE INVENTION

Stereoisomers are compounds made up of the same atoms bonded by the same sequence of bonds but having different three-dimensional structures, which are not interchangeable. These
10 three-dimensional structures are called configurations, e.g. *R* and *S*. Optically active compounds, which have one chiral atom or more, exist as two or more isomers, called enantiomers. Enantiomers are mirror image of one another and have identical physical properties, except for the fact that they rotate the plane of polarized light in opposite directions, (+) clockwise for the dextro isomer and (-) counterclockwise for the levo isomer. Likewise, they have identical
15 chemical properties except when interacting with stereospecific compounds. When the rates at which each enantiomer reacts or interacts with another chiral compound are sufficiently different, a clear divergence in activity is observed, and many compounds that are biologically active have inactive enantiomers.

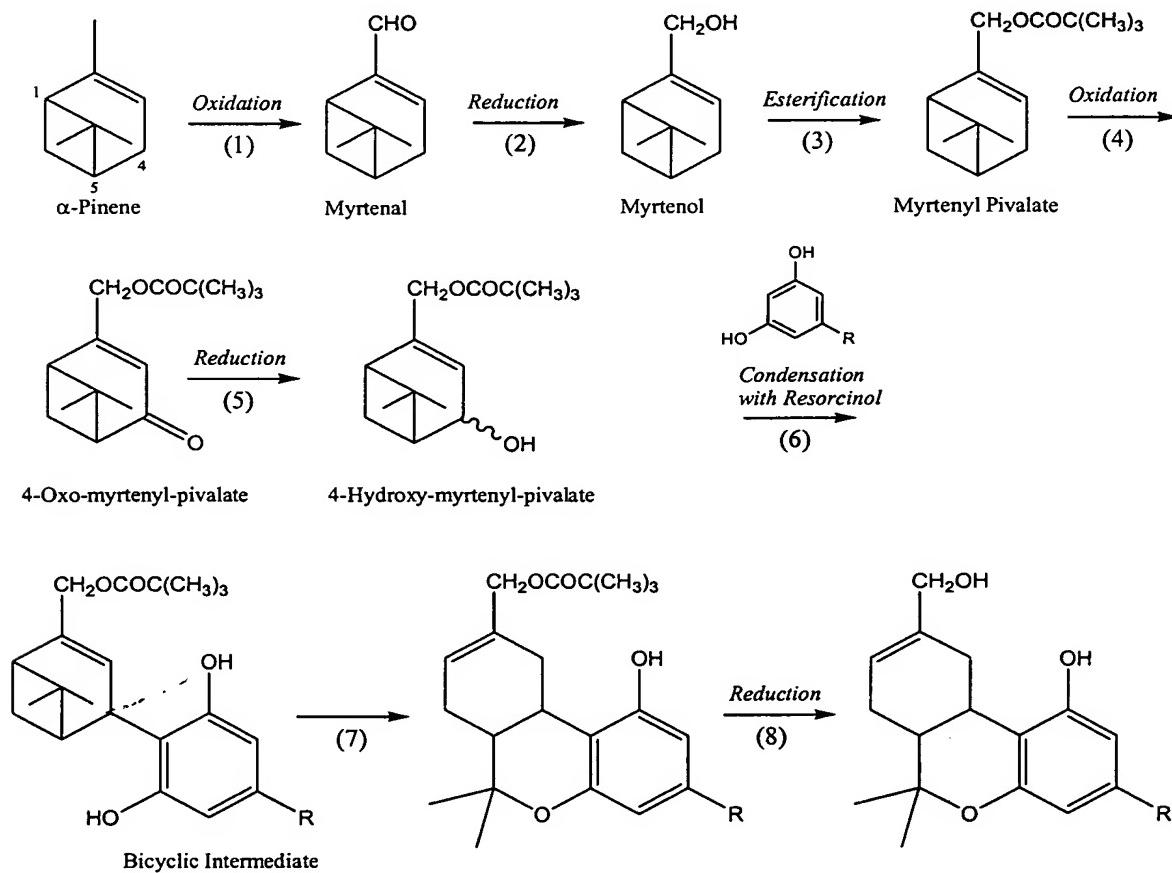
In some cases resolving a racemic mixture into the separate enantiomers will be only of
20 academic interest, to assess the differences in activity of the purified compounds. However, in some instances one of the enantiomers is not only devoid of the biochemical activity of interest but has its own deleterious activity. In these circumstances the separation of the enantiomers has significant practical impact, especially when the compound of interest has therapeutic activity.

Research on the chemistry of *Cannabis sativa* was initiated back in the nineteenth century,
25 due to the interest in the long known therapeutical effects of this plant. But terpenoids being very difficult to isolate, the scientific community had to wait for the twentieth century and technical progress in analytical instrumentation for the purification and identification of natural constituents of Cannabis. The first isolation, in a pure form, of Δ^9 -tetrahydrocannabinol (Δ^9 -THC), Cannabis' major psychoactive constituent, was reported by Gaoni Y. et al. in 1964. The
30 absolute configuration of Δ^9 -THC was established by Mechoulam R. et al. in 1967 and found to be of $(-)(3R,4R)$ stereochemistry. It was later found that the psychotropic activity of

cannabinoids resides in the natural (*3R,4R*) series, while the opposite enantiomeric synthetic series (*3S,4S*) was free of these undesirable effects. In 1967 the group of Mechoulam and coworkers also achieved the synthesis of THC (for a review see Mechoulam R. and Hanuš L., Chem. Phys. Lip 108: 1-13, 2000). Thus, it was clear that in order to exploit the therapeutical value of cannabinoids, medicinal chemists would have first to “neutralize” the highly undesirable psychoactive effects, for instance by preparation and selection of synthetic non-psychotropic enantiomers.

Basically the synthetic route involves the condensation of a monoterpenoid with a resorcinol as shown in scheme 1. The structure of the final product depends on the substituents of the initial reagents, similarly its enantiomeric purity depends on the enantiomeric purity of the reagents.

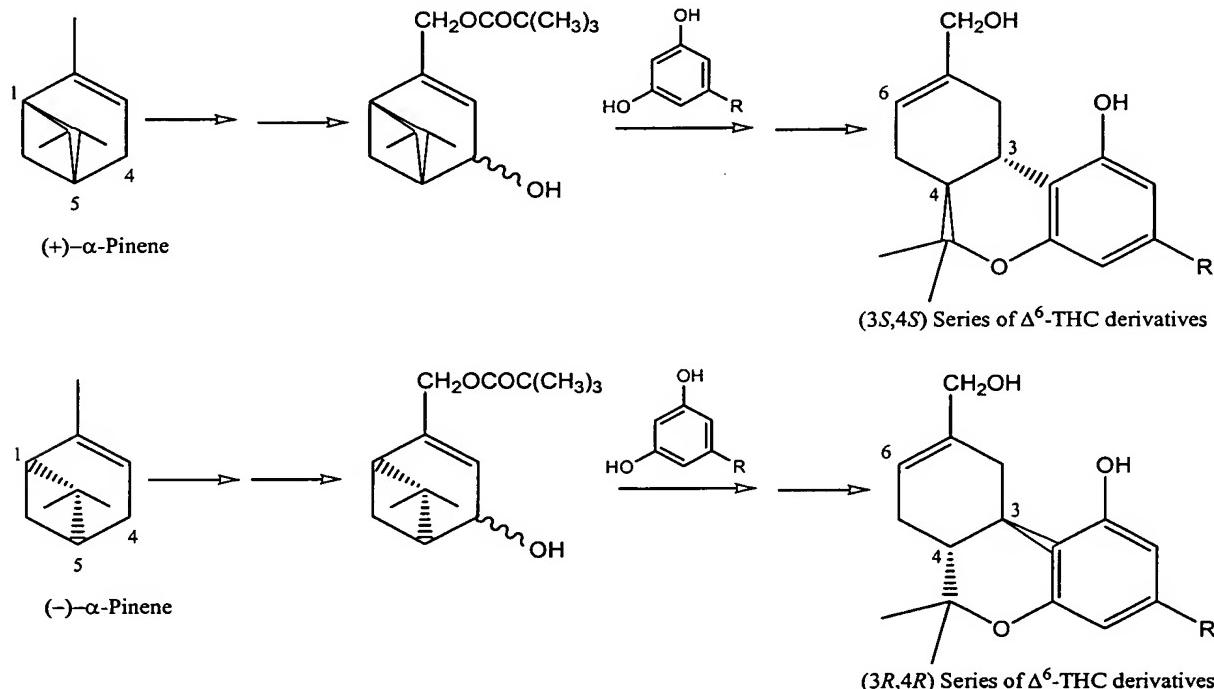
Scheme 1



The chirality of the starting material, α -pinene, determines the chirality of the final compound. Using (+)- α -pinene will yield (*1S,5R*) myrtenol, and corresponding derivatives, down to classical cannabinoid analogs of the (*3S,4S*) configuration. Using (-)- α -pinene will yield (*1R,5S*) myrtenol, and corresponding derivatives, down to classical cannabinoid analogs of the

(3*R*,4*R*) configuration, see scheme 2. It should be noted that for historical reasons, these cannabinoid analogs are still named following the previous nomenclature, where the terpenic ring was the base for the numbering system. Then the chiral centers of THC type cannabinoids were at carbon atoms 3 and 4. The accepted nomenclature is now based on the phenolic ring as the starting point for numbering. Thus, THC that was previously described as Δ^1 -THC was later renamed Δ^9 -THC, similarly Δ^6 -THC was renamed Δ^8 -THC, and the chiral centers are at carbons 6a and 10a.

Scheme 2



When the R substituent in schemes 1 and 2 is 1,1-dimethyl-heptyl, the compounds obtained are termed HU-210, for the (-)(3*R*,4*R*) enantiomer and HU-211, for the (+)(3*S*,4*S*) enantiomer. This pair of enantiomers was among the first to be efficiently separated, and studies performed established the fact that cannabinoid action is highly stereospecific opening the way to the search for cannabinoid receptors. HU-210 was shown to be a hundred times more psychoactive than THC, the natural component of hashish, and a thousand times more psychoactive than HU-211 in a series of animal tests (Mechoulam R. et al., Tetrahedron Asymmetry 1(5): 315-8, 1990).

The quantitative criterion of the minimum acceptable degree of optical purity of an intended therapeutic enantiomer is dictated by the pharmacological potency of the contamination. The higher the psychotropic activity of the enantiomer, the stricter is the

requirement for optical purity. The enantiomeric pair HU-210 and HU-211 is an extreme example of such a situation and the very highly undesirable psychotropic effects of HU-210 require that HU-211 should be of very high enantiomeric purity.

It was previously disclosed that the compound HU-211 could be produced on the laboratory scale in purported enantiomeric excess (e.e.) of at least 99.8% over HU-210 (Mechoulam R. et al., Tetrahedron Asymmetry 1(5): 315-8, 1990). In point of fact, the synthetic and analytical methods that were used to generate those data were not sufficiently reliable to ensure that such a high enantiomeric excess could reproducibly be attained.

Moreover, during subsequent clinical trials, therapeutic dosages for humans have been shown to range from tens to hundreds of milligrams per subject, requiring that for pharmaceutical use HU-211 must actually be of enantiomeric purity even higher than any reported previously. Furthermore, for pharmaceutical use reproducibility of the synthetic procedures, adherence to product specifications and the ability to produce the compound on a large scale are necessary features of the active pharmaceutical ingredient.

As already stated, two parameters will determine the stereospecificity of the final synthetic cannabinoid prepared according to scheme 1. First, the chirality of the starting material and second its enantiomeric purity. Thus, it is expected that using (+)- α -pinene of 95% enantiomeric excess will lead to synthesis of a (3S,4S) THC type compound with the same level of enantiomeric purity. However, the synthetic route for the preparation of THC-type compounds allows for stereochemical purification through recrystallization at two steps, for the 4-oxo-myrenyl-pivalate and for the final compound. This observation made possible the synthesis on a laboratory scale of the enantiomers in e.e. of 99.8%, as determined by HPLC analysis. Small-scale preparation of HU-211 opened the way to the study of its properties in numerous in vitro and in vivo systems. This research led to the discovery of HU-211 multifaceted therapeutical characteristics.

HU-211, 1,1-dimethylheptyl-(3S,4S)-7- hydroxy- Δ^6 -tetrahydrocannabinol, was disclosed in US 4,876,276 and subsequently assigned the trivial chemical name dexanabinol (CAS number: 112-924-45-5). At first, potential therapeutic applications of dexanabinol included known attributes of marijuana itself such as anti-emesis, analgesia, and anti-glaucoma, as disclosed in US Patent No. 4,876,276. Further research revealed unexpected properties for dexanabinol and its derivatives, for instance it was later established that those novel synthetic compounds could be divided into sets according to their ability to block the NMDA receptor, as disclosed in US Patent Nos. 5,284,867, 5,521,215 and 6,096,740. The capacity of dexanabinol and some of its analogues to block glutamate neurotoxicity has therapeutical implications for treating acute

injuries to the central nervous system, including mechanical trauma, prolonged seizures, deprivation of glucose supply, and compromised blood supply (e.g. cardiac arrest or stroke), as well as chronic degenerative disorders characterized by neuronal loss (e.g. Alzheimer's disease, Huntington's chorea, and Parkinsonism), and poisoning affecting the central nervous system
5 (e.g. strychnine, picrotoxin and organophosphorous poisoning).

Moreover, dexanabinol and its analogues seemed to share anti-oxidative, immunomodulatory and anti-inflammatory properties in addition to their capacity to block the NMDA receptor, as disclosed in US Patent Nos. 5,932,610 and 6,331,560. The convergence of such diverse and crucial therapeutical activities in the dexanabinol molecule made it an excellent
10 candidate for prevention or treatment of a variety of clinical conditions. Currently, the neuroprotective effects of dexanabinol are being assessed in clinical trials. One trial is being conducted to determine the efficacy of dexanabinol in patients suffering from traumatic brain injuries (TBI), while in another trial dexanabinol is administered during surgical procedures to assess its preventive or alleviating effect on post-operative mild cognitive impairment (MCI).

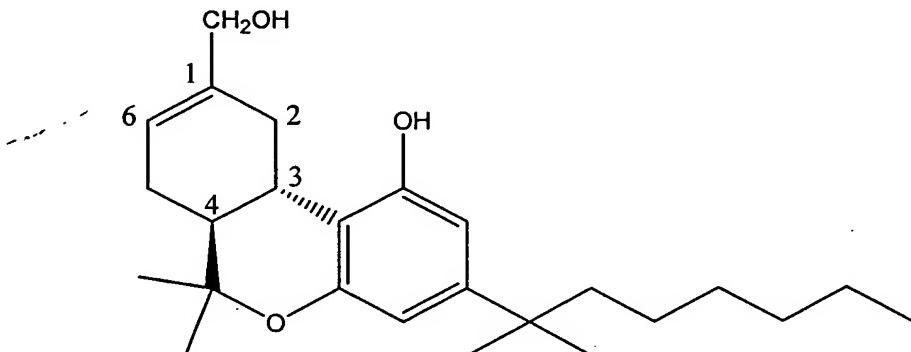
15 Although certain disclosures have addressed the issue of the enantiomeric purity of THC type of compounds, there remains a recognized need for a commercially reproducible dexanabinol compound of high enantiomeric purity for clinical uses.

SUMMARY OF THE INVENTION

It is an object of the present invention to provide enantiomerically pure dexanabinol for use
20 as an active ingredient in pharmaceutical compositions for clinical applications.

The present invention encompasses a compound of formula (I):

Formula I



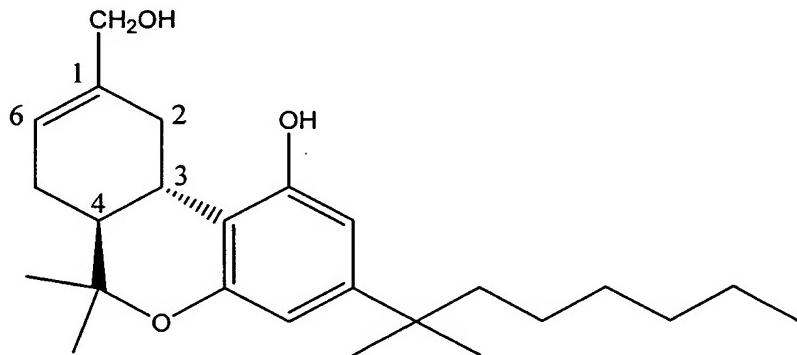
having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the
25 (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound.

More preferably the compound of formula (I), dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.92% over the (3*R*,4*R*) enantiomer.

5 Most preferably the compound of formula (I), dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.95% over the (3*R*,4*R*) enantiomer.

The present invention further encompasses pharmaceutical compositions comprising as an active ingredient dexanabinol, a compound of formula (I):

Formula I



10

having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound.

More preferably the active ingredient of the above-defined pharmaceutical composition, dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.92% over the (3*R*,4*R*) enantiomer.

Most preferably the active ingredient of the above-defined pharmaceutical composition, dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.95% over the (3*R*,4*R*) enantiomer.

The present invention also relates to pharmaceutical compositions comprising as an active 20 ingredient enantiomerically pure dexanabinol, having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound as above defined, further comprising a pharmaceutically acceptable diluent, carrier or excipient necessary to produce a physiologically acceptable and stable formulation.

The pharmaceutical compositions can be administered by any conventional and appropriate route including oral, parenteral, intravenous, intramuscular, subcutaneous, transdermal, intrathecal, rectal or intranasal.

5 Prior to their use as medicaments for preventing, alleviating or treating an individual in need thereof, the pharmaceutical compositions may be formulated in unit dosage. The selected dosage of active ingredient depends upon the desired therapeutic effect, the route of administration and the duration of treatment desired.

A further embodiment of the present invention provides a method of preventing, alleviating or treating a patient for indications including but not limited to acute neurological 10 disorders, chronic degenerative diseases, CNS poisoning, post-operative cognitive impairment, inflammatory diseases or disorders, autoimmune diseases or disorders, pain, emesis, glaucoma and wasting syndromes, by administering to said patient a prophylactically and/or therapeutically effective amount of a pharmaceutical composition comprising as an active ingredient enantiomerically pure dexanabinol, having the (3S,4S) configuration and being in enantiomeric 15 excess of at least 99.90% over the (3R,4R) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound as above defined.

A further embodiment of the present invention provides use for the manufacture of a medicament for preventing, alleviating or treating acute neurological disorders, chronic degenerative diseases, CNS poisoning, post-operative cognitive impairment, inflammatory 20 diseases or disorders, autoimmune diseases or disorders, pain, emesis, glaucoma and wasting syndromes, of enantiomerically pure dexanabinol, having the (3S,4S) configuration and being in enantiomeric excess of at least 99.90% over the (3R,4R) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound as above defined.

BRIEF DESCRIPTION OF THE FIGURES

25 Figure 1 shows expanded HPLC chromatograms of four pharmaceutical grade, large scale, batches of enantiomerically pure dexanabinol.

Figure 2 shows the profile of dexanabinol plasma concentration along time, following single or multiple injections of specified doses in the various species tested.

30 Figure 3 shows the profile of dexanabinol concentrations in plasma and brain of rats injected with 4 mg/kg of the drug.

DETAILED DESCRIPTION OF THE INVENTION

It is an object of the present invention to provide ultrapure dexanabinol characterized by an enantiomeric excess of at least 99.90%, more preferably 99.92% and most preferably 99.95%, for use as an active pharmaceutical ingredient in compositions for clinical applications.

5 In the present specification and claims which follow the terms HU-211, dexanabinol, 1,1-dimethylheptyl-(3*S*,4*S*)-7-hydroxy- Δ^6 -tetrahydrocannabinol and (+)(6a*S*,10a*S*)-6,6-dimethyl-3-(1,1-dimethylheptyl)-1-hydroxy-6a,7,10,10a-tetrahydro-6H-dibenzo[b,d]pyran-9-methanol are alternatively used to represent the same chemical entity.

10 In the present specification and claims which follow the terms HU-210, 1,1-dimethylheptyl-(3*R*,4*R*)-7-hydroxy- Δ^6 -tetrahydrocannabinol and (-)(6a*R*,10a*R*)-6,6-dimethyl-3-(1,1-dimethylheptyl)-1-hydroxy-6a,7,10,10a-tetrahydro-6H-dibenzo[b,d]pyran-9-methanol are alternatively used to represent the same chemical entity.

15 In the present specification and claims which follow the term "enantiomeric excess" (e.e.) represents the percent excess of one enantiomer over the other and is calculated using the following equation:

Percent e.e. = $100 * ([\text{enantiomer 1}] - [\text{enantiomer 2}]) / ([\text{enantiomer 1}] + [\text{enantiomer 2}])$. Thus the formula used to calculate the enantiomeric excess of dexanabinol over HU-210 is $100 * ([\text{HU-211}] - [\text{HU-210}]) / ([\text{HU-211}] + [\text{HU-210}])$, wherein the concentration of the enantiomers is determined by HPLC and expressed as percent weight by weight.

20 The enantiomeric purity of the active ingredient is determined by types of tests known in the art, for example chiral HPLC methods and reverse phase HPLC. The present invention required development of novel modified chiral HPLC methods (adapted from Levin S. et al., Journal of Chromatography A. 654: 53-64, 1993) exemplified hereinbelow, in conjunction with RP-HPLC. Analytical methods previously disclosed in the art were not validatable and did not 25 provide reliable and reproducible results. Among the reasons for the inaccuracy of previously known methods is their failure to resolve certain impurities that can elute with parameters overlapping those of the desired product itself.

30 The scaled up synthetic procedures according to the present invention, generally adhere to the synthetic schemes used previously, with modifications to enable good manufacturing practice. The improvements implemented were required to obtain pharmaceutical grade dexanabinol reproducibly and with the required elevated standard of enantiomeric purity.

Dexanabinol is capable of further forming pharmaceutically acceptable salts and esters. "Pharmaceutically acceptable salts and esters" means any salt and ester that is pharmaceutically

acceptable and has the desired pharmacological properties. Such salts include salts that may be derived from an inorganic or organic acid, or an inorganic or organic base, including amino acids, which is not toxic or otherwise unacceptable. The present invention also includes within its scope solvates of dexanabinol and salts thereof, for example, hydrates. In the present specification the term "prodrug" represents compounds which are rapidly transformed in vivo to dexanabinol, for example by hydrolysis in the blood. All of these pharmaceutical forms are intended to be included within the scope of the present invention.

Water-soluble derivatives of dexanabinol were synthesized and investigated over the years. They can be used as prodrugs, or active analogs depending on their hydrolytic and enzymatic stability and on their intrinsic activity. The two hydroxyl groups present in the dexanabinol molecule were targeted for modifications and various polar combinations or combinations bearing a permanent charge were synthesized as esters at the allylic or phenolic hydroxyls. Modifications included glycinate and N-substituted glycimates, esters of amino acids containing tertiary or quaternary heterocyclic nitrogen, phosphates, and hemiesters of dicarboxylic acids.

Synthetic procedures, water solubility and stability in buffers and human plasma, as well as in vivo tissue distribution of water-soluble dexanabinol analogues, were abundantly described (US Patent No. 6,096,740; Pop E. et al., Pharm. Res. 13: 62-9, 1996; Pop E. et al., Pharm. Res. 13: 469-75, 1996; Pop E. et al., J. Pharm. Sci. 88: 1156-60, 1999; Pop E. et al., Pharmazie 55: 167-71, 2000). Several derivatives possess the required properties to be used as water-soluble prodrugs: they are soluble and fairly stable in water, but rapidly hydrolyze in human blood into parent dexanabinol.

In the present specification and claims which follow "prophylactically effective" is intended to qualify the amount of compound which will achieve the goal of prevention, reduction or eradication of the risk of occurrence of the disorder, while avoiding adverse side effects. The term "therapeutically effective" is intended to qualify the amount of compound that will achieve, with no adverse effects, alleviation, diminished progression or treatment of the disorder, once the disorder cannot be further delayed and the patients are no longer asymptomatic. The compositions of the present invention are prophylactic as well as therapeutic.

The "individual" or "patient" for purposes of treatment includes any human or mammalian subject affected by any of the diseases where the treatment has beneficial therapeutic impact.

By virtue of the anti-inflammatory and immunomodulatory properties of dexanabinol, it will be recognized that the compositions according to the present invention will be useful for treating indications having an inflammatory or autoimmune mechanism involved in their etiology or pathogenesis. Such diseases or disorders are exemplified by multiple sclerosis,

amyotrophic lateral sclerosis, systemic lupus erythematosus, myasthenia gravis, diabetes mellitus type I, sarcoidosis; skeletal and connective tissue disorders including arthritis, rheumatoid arthritis, osteoarthritis and rheumatoid diseases; ocular inflammation related disorders; skin related disorders including psoriasis, pemphigus and related syndromes, delayed-type hypersensitivity and contact dermatitis; respiratory diseases including cystic fibrosis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease, asthma, allergic rhinitis or lung inflammation, idiopathic lung fibrosis, tuberculosis, and alveolitis; kidney diseases including renal ischemia, nephrites, nephritic syndromes and nephrosis characterized by glomerular nephritides; liver diseases both acute and chronic such as cirrhosis; gastrointestinal diseases including inflammatory bowel diseases, ulcerative colitis, Crohn's disease and gastritis, polyposis and cancer of the bowel, especially the colon; infectious diseases generated by certain bacterial, viral and parasitic invasion and sepsis that might result from injury; and post-operative complications following angioplasty, circulatory recovery techniques, prosthetic implants and tissue or organ transplants, including graft rejection.

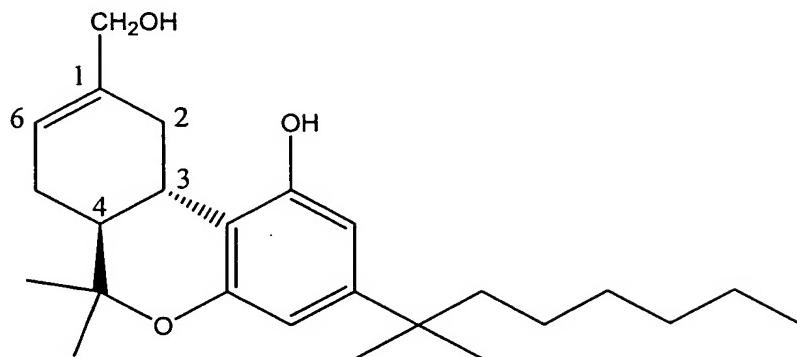
By virtue of the neuroprotective properties of dexanabinol, it will be recognized that the compositions according to the present invention will be useful in treating acute neurological disorders, resulting either from ischemic or traumatic damage, including but not limited to stroke, head trauma and spinal cord injury. The composition of the present invention may also be effective in preventing or treating certain chronic degenerative diseases that are characterized by gradual selective neuronal loss such as Parkinson's disease, Alzheimer's disease, AIDS dementia, Huntington's chorea, and prion-associated neurodegeneration. The compositions may further be effective in prevention or diminution of post-operative cognitive impairment and of CNS poisoning, for instance by strychnine or organophosphorous compounds.

By virtue of the analgesic properties of dexanabinol, it will be recognized that the compositions according to the present invention will be useful in treating pain including peripheral, neuropathic and referred pain.

The compositions of the present invention will also be effective in relieving emesis and treating glaucoma, retinal eye diseases and cachexia due to acquired immunodeficiency syndrome, neoplasia or other wasting diseases.

The present invention provides a compound of formula (I):

Formula I



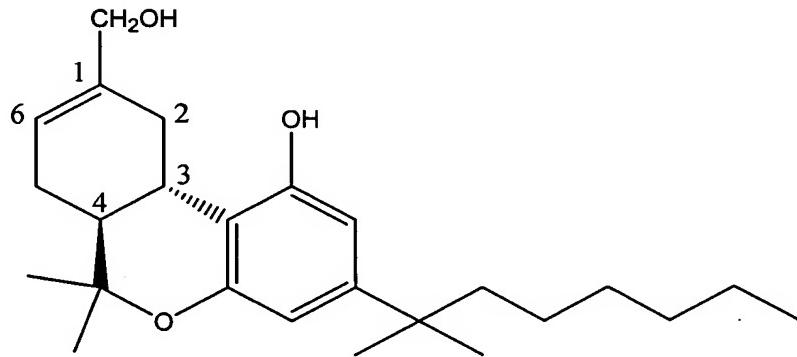
having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the
5 (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound.

More preferably the compound of formula (I), dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.92% over the (3*R*,4*R*) enantiomer.

Most preferably the compound of formula (I), dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.95% over the (3*R*,4*R*) enantiomer.

The present invention provides pharmaceutical compositions comprising as an active ingredient dexanabinol, a compound of formula (I):

Formula I



15 having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound.

More preferably the active ingredient of the above-defined pharmaceutical composition, dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.92% over the (3*R*,4*R*) enantiomer.

Most preferably the active ingredient of the above-defined pharmaceutical composition, 5 dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, is in enantiomeric excess of at least 99.95% over the (3*R*,4*R*) enantiomer.

The present invention also provides pharmaceutical compositions comprising as an active 10 ingredient an enantiomerically pure compound of formula (I) having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90%, more preferably 99.92% and most 15 preferably 99.95%, over the (3*R*,4*R*) enantiomer, further comprising a pharmaceutically acceptable diluent or carrier.

The pharmaceutical compositions contain in addition to the active ingredient conventional 15 pharmaceutically acceptable carriers, diluents and excipients necessary to produce a physiologically acceptable and stable formulation. Some compounds of the present invention are characteristically hydrophobic and practically insoluble in water with high lipophilicity, as expressed by their high octanol/water partition coefficient expressed as log P values, and formulation strategies to prepare acceptable dosage forms will be applied. Enabling 20 therapeutically effective and convenient administration of the compounds of the present invention is an integral part of this invention.

For water-soluble derivatives of dexanabinol standard formulations will be utilized. Solid 25 compositions for oral administration such as tablets, pills, capsules, softgels or the like may be prepared by mixing the active ingredient with conventional, pharmaceutically acceptable ingredients such as corn starch, lactose, sucrose, mannitol, sorbitol, talc, polyvinylpyrrolidone, polyethyleneglycol, cyclodextrins, dextrins, glycerol, polyglycolized glycerides, tocopheryl 30 polyethyleneglycol succinate, sodium lauryl sulfate, polyethoxylated castor oils, non-ionic surfactants, stearic acid, magnesium stearate, dicalcium phosphate and gums as pharmaceutically acceptable diluents. The tablets or pills can be coated or otherwise compounded with pharmaceutically acceptable materials known in the art, such as microcrystalline cellulose and cellulose derivatives such as hydroxypropylmethylcellulose (HPMC), to provide a dosage form affording prolonged action or sustained release. Other solid compositions can be prepared as 35 suppositories, for rectal administration. Liquid forms may be prepared for oral administration or for injection, the term including but not limited to subcutaneous, transdermal, intravenous, intrathecal, intralesional, adjacent to or into tumors, and other parenteral routes of administration. The liquid compositions include aqueous solutions, with or without organic

cosolvents, aqueous or oil suspensions including but not limited to cyclodextrins as suspending agent, flavored emulsions with edible oils, triglycerides and phospholipids, as well as elixirs and similar pharmaceutical vehicles. In addition, the compositions of the present invention may be formed as aerosols, for intranasal and like administration. Topical pharmaceutical compositions 5 of the present invention may be formulated as solution, lotion, gel, cream, ointment, emulsion or adhesive film with pharmaceutically acceptable excipients including but not limited to propylene glycol, phospholipids, monoglycerides, diglycerides, triglycerides, polysorbates, surfactants, hydrogels, petrolatum or other such excipients as are known in the art.

Prior to their use as medicaments, the pharmaceutical compositions will generally be 10 formulated in unit dosage. The active dose for humans is generally in the range of from 0.05 mg to about 50 mg per kg body weight, in a regimen of 1-4 times a day. The preferred range of dosage is from 0.1 mg to about 20 mg per kg body weight. However, it is evident to one skilled in the art that dosages would be determined by the attending physician, according to the disease 15 to be treated, its severity, the method and frequency of administration, the patient's age, weight, gender and medical condition, contraindications and the like. The dosage will generally be lower if the compounds are administered locally rather than systematically, and for prevention or chronic treatment rather than for acute therapy.

A further aspect of the present invention provides a method of preventing, alleviating or 20 treating a patient for indications as above described, by administering to said patient a prophylactically and/or therapeutically effective amount of a pharmaceutical composition comprising as an active ingredient enantiomerically pure dexanabinol, having the (3S,4S) configuration and being in enantiomeric excess of at least 99.90% over the (3R,4R) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound as above defined.

A further aspect of the present invention relates to the use for the manufacture of a 25 medicament for preventing, alleviating or treating indications as above described, of enantiomerically pure dexanabinol, having the (3S,4S) configuration and being in enantiomeric excess of at least 99.90% over the (3R,4R) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound as above defined.

The principles of the present invention will be more fully understood by reference to the 30 following examples, which are to be construed in a non-limitative manner.

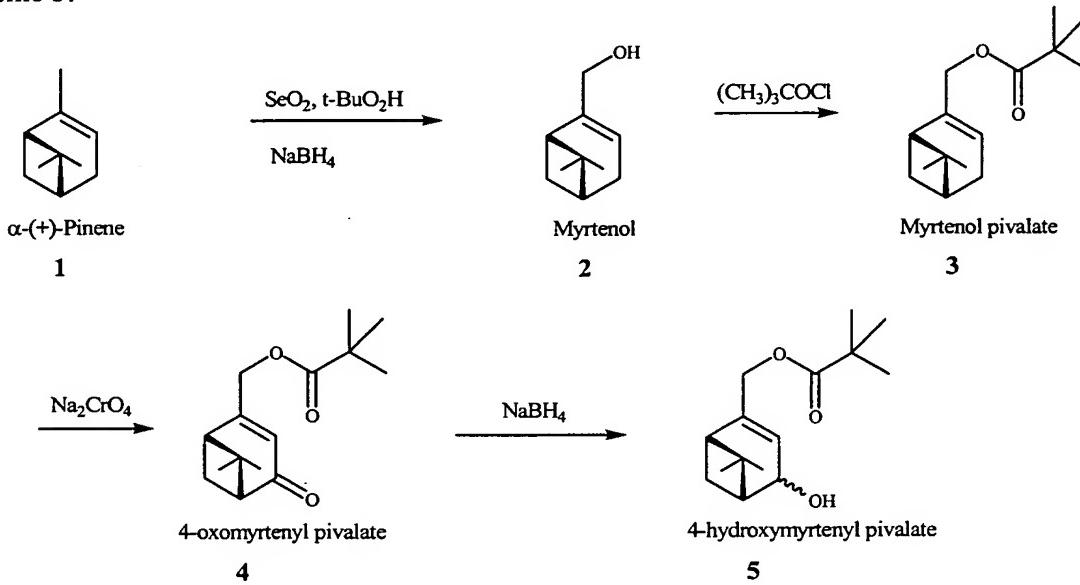
EXAMPLES

Example 1.

Preparation of dexanabinol of high enantiomeric purity.

Dexanabinol is manufactured on a commercial scale in eleven steps starting from (+)- α -pinene (1 in Scheme 3) and involves coupling of 2 main intermediates (Scheme 5), (+) 4-hydroxymyrtenyl pivalate (5 in Scheme 3) and 5'-(1',1'-dimethylheptyl)-resorcinol (12 in Scheme 4).

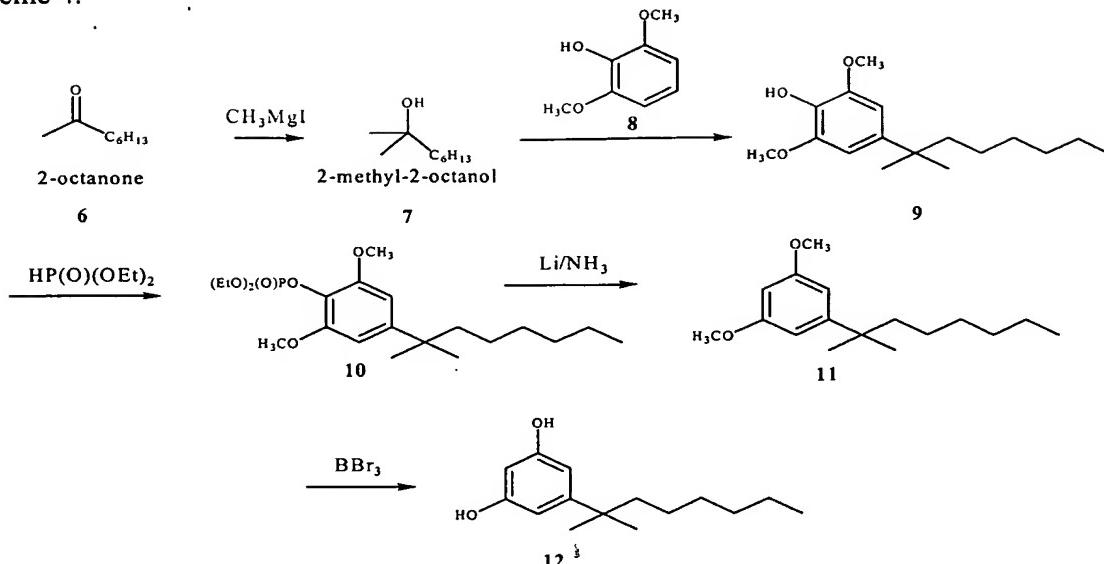
Scheme 3.



10

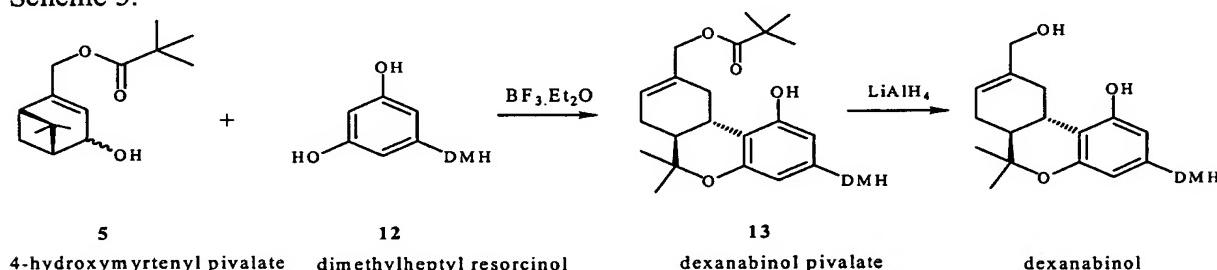
The (+) 4-hydroxymyrtenyl pivalate (5) is synthesized from (+)- α -pinene (1) by a 4-step procedure *via* (+) myrtenol (2). By oxidation of 1 with *t*-butylhydroperoxide in the presence of SeO_2 on silica gel a mixture of myrtenol and myrtenal is obtained, further reduced to myrtenol by sodium borohydride. Esterification of the myrtenol with pivaloyl chloride gives (+) myrtenol pivalate (3), which by sodium chromate oxidation leads to (+)-4-oxomyrtenyl pivalate (4). Borohydride reduction of (4) leads to (5).

Scheme 4.



The 5-(1',1'-dimethylheptyl)resorcinol (12) is obtained by a 5-step synthesis which starts from 2-octanone (6) and 2,6-dimethoxyphenol (8). In this procedure, (6) is transformed to 2-methyl-2-octanol (7) (Grignard reaction), which then alkylates 8 in methansulfonic acid to give (1',1'-dimethylheptyl)-2,6-dimethoxyphenol (9). By reacting 9 with diethylphosphonate, the (1',1'-dimethylheptyl)-2,6-dimethoxyphenyl diethylphosphite (10) is obtained. Treatment of 10 with lithium/ammonia followed by demethylation with boron tribromide of the resulting (1',1'-dimethylheptyl)-3,5-dimethoxybenzene (11) affords the 5-substituted resorcinol 12.

Scheme 5.



The final steps are described in Scheme 5, wherein the 1,1-dimethyl-heptyl substituent is abbreviated DMH. Coupling of (5) and (12) takes place in the presence of boron trifluoride diethyletherate and results in the pivaloyl ester of dexanabinol (13), which is subsequently deprotected with lithium aluminium hydride to give the final dexanabinol substance.

The advantages of this process over the previously known laboratory scale procedure, as described in U.S. Patent No. 4,876,276, are evident to persons skilled in the art and include scale-up ability, improved yield, simplified process, reduced use of toxic chemicals or dangerous reagents all leading to a safer and more cost effective production. The exact conditions of the

clinical grade, intermediate scale, synthesis of dexanabinol of high enantiomeric purity are described below.

Step 1 (i): Oxidation of (+)- α -pinene with selenium dioxide

To 0.13 molar equivalents of selenium dioxide on silica gel a 1:3 (w/v) solution of α -pinene (1) in methylene chloride is added. To the mixture is added 0.46 molar equivalents of 70% t-butyl-hydroperoxide at 30°C. The mixture is stirred at 30°C for 46-50 hours and filtered. The solvents are removed under reduced pressure (50-100 Torr) at 50°C. A mixture of (+) myrtenol and (+) myrtenal results.

Step 1 (ii): Reduction of myrtenal with sodium borohydride

The residue from step 1 is dissolved in methanol, cooled to 0-5°C and treated with 0.5 molar equivalent of sodium borohydride over 2-3 hours, maintaining the temperature at 0-5°C. The mixture stirred for an additional 30-60 minutes at 0-5°C, then diluted with one volume of ice water and extracted three times with 0.25 volumes of methylene chloride (each). The combined organic solutions are washed four times with one volume (each) water, dried over 0.05 part anhydrous sodium sulphate, filtered and the solvent is removed under vacuum (50-100 Torr) at 80°C, resulting in (+) myrtenol (2).

Step 2: Esterification of (+) myrtenol with pivaloyl chloride

To a solution of 2 in 1.5 volumes of anhydrous pyridine is added 1.6 molar equivalents of pivaloyl chloride at (-15)-(-10)°C over 3 hours. The mixture is diluted with 0.2 volumes of pyridine and stirred overnight at 20-25°C. Two volumes of ice water are added to the mixture and the resulting ester is extracted twice with 0.5 volumes (each) of methylene chloride. The solvents (methylene chloride and pyridine) are removed under reduced pressure (50-100 Torr) at 80°C. The resulting myrtenyl pivalate (3) is an oily material. The crude myrtenyl pivalate is used for the following step without further purification, simplifying the process.

Step 3: Oxidation of (+) myrtenyl pivalate with sodium chromate

A solution of 3 in 6 volumes of acetic acid-acetic anhydride (1:1) is treated with 3.3 molar equivalents of sodium chromate at 10-15°C, over 3-5 hours. The mixture is stirred at 20°C for 16-20 hours, then at 45-50°C for 24 hours. After cooling at 20-25°C, 0.4 volumes of ice water are added and the mixture is extracted five times with 0.2 volumes (each) of methylene chloride. The combined extracts are washed five times with 0.5 volume (each) of 20% aqueous sodium chloride and concentrated to 1/6 of their volume. The concentrate is washed with one volume of 54% aqueous potassium carbonate and dried over 0.33 parts of anhydrous sodium sulphate. The resulting solution is passed through 0.33 parts of silica gel 60-230 mesh using an eluent of 3.5

volumes of methylene chloride. After removing the solvent under reduced pressure at 50-100 Torr at a final temperature of 80°C, the residue is distilled at 120-165°C and 0.1-0.15 Torr. The distillate is diluted with two volumes of n-pentane and kept at -20°C for 40 hours. The resulting crystals of 4-oxomyrtenyl pivalate (4) are filtered, rinsed with cold pentane and dried in a clean, well-ventilated hood. A second crop of material can be obtained from the mother liquors, by removing the solvent and distilling the residue in vacuum and crystallisation from pentane.

5 **Step 4: Reduction of 4-oxomyrtenyl pivalate with sodium borohydride**

To a solution of 4 in 16 volumes of methanol is added 1.32 molar equivalents of sodium borohydride at (-15)-(-10) °C over 2-3 hours. Sodium borohydride advantageously replaces the lithium hydrido-tri-t-butoxylaminate previously used in the laboratory scale process. The molar excess of sodium borohydride versus 4 (1.32) is much reduced as compared to lithium hydrido-tri-t-butoxylaminate (more than 10 fold over 4). The mixture is stirred for another 3 hours at -10°C and 0.1 volume ice-water is added. Three volumes of water are added and the mixture is extracted with 2.5 volumes of hexane. The extracts are washed three times with 0.4 volumes (each) of water and dried over 0.03 parts of anhydrous sodium sulphate. The solvent is removed under reduced pressure and 50-100 Torr and temperature below 70°C, affording the 4-hydroxymyrtenyl pivalate (5) as an oil.

10 **Step 5: Grignard synthesis of 1',1'-dimethylheptanol from 2-octanone**

To a suspension of 1.25 molar equivalents of magnesium turnings in 13.7 parts of ethyl ether, is added 0.004 equivalents of iodine while stirring. The stirring is continued until the colour of the solution fades to clear or to slightly yellow. To the resulting mixture is added 1.12 molar equivalents of iodomethane over 4-8 hours so that a gentle reflux is maintained. After another 2 hours one molar equivalent of octanone (6) is added over a period of 4-6 hours. The mixture is stirred for 2 hours at 20-25°C then the stirring is discontinued and the mixture is allowed to settle overnight. The solution is decanted onto 2 parts of ice water, and acidified to pH 5.5-6.0 with acetic acid. The layers are separated and the aqueous phase is extracted three times with 0.33 volumes (each) of ethyl acetate. The extracts are combined, washed with 1 volume of water, 1 volume 5% sodium bicarbonate, twice with 10% sodium chloride (each) and dried over 0.1 parts of anhydrous sodium sulphate. The solvent is removed at 50°C and 45-50 Torr. The reaction product 1,1-dimethylheptanol (7) is a colourless or pale yellow oil.

15 **Step 6: Alkylation of 2,6-dimethoxyphenol with 1',1'-dimethylheptanol**

To a solution of 2,6-dimethoxyphenol (8) in 1.3 volumes of methansulfonic acid is added 1.1 molar equivalents of 7 and the resulting mixture is stirred under argon at 50-55°C over a period of 30 hours and then poured onto 2.5 parts of ice water. The mixture is extracted three

times with 0.5 volumes (each) of methylene chloride and the combined organics are washed once with 1 volume of water, once with 0.4 volume of 7% sodium bicarbonate, and twice with 1 volume of saturated aqueous solution of sodium chloride (each). The organic layers are dried overnight on 0.05 parts of anhydrous sodium sulphate, and the solvent is removed in vacuum at 5 80°C to afford 4-(1',1'-dimethylheptyl)-2,6-dimethoxyphenol (**9**) as an oil, used directly in the next step.

Step 7: Esterification of 4-(1',1'-dimethylheptyl)-2,6-dimethoxyphenol with diethyl phosphite

To a solution of **9** in 0.5 volumes of carbon tetrachloride is added 1.5 molar equivalents of diethyl phosphite. The mixture is cooled to -10°C and treated with 1.5 molar equivalents of triethylamine over a period of 5 hours while cooling. The mixture is then gradually warmed 10 overnight to room temperature (20-25°C), diluted with 2.5 volumes of methylene chloride and subsequently washed with 0.5 volumes of water, once with 0.5 volume of 0.5 N aqueous solution of 2 N NaOH, once with 0.5 volume of 0.5 N aqueous solution of hydrochloric acid and then 15 three times with 0.25 volume of saturated aqueous solution of sodium chloride (each). The organics are dried over 0.1 part of anhydrous sodium sulphate and the solvent removed in vacuum. The resulting oil is diluted with an equal amount of petroleum ether (w/v) and 20 crystallized at room temperature for 15-24 hours. The obtained crystals of 4-(1',1'-dimethylheptyl)-2,6-dimethoxyphenyl diethylphosphate (**10**) are filtered, washed with petroleum ether and dried. An additional crop of product may be obtained by concentrating the mother liquor and recrystallizing as above.

Step 8: Reduction of 4-(1',1'-dimethylheptyl)-2,6-dimethoxyphenyl diethylphosphate with lithium/ammonia

A solution of **10** in 2 parts ethyl ether and 0.4 parts tetrahydrofuran is added dropwise to 1.25 volumes of liquid ammonia, followed by the addition of 2.3 molar equivalents of lithium 25 metal in small pieces at a rate to maintain a blue colour. The mixture is stirred for one hour and then poured into four volumes of 14% aqueous solution of ammonium chloride. The organic layer is separated retained and the aqueous layer is extracted three times with 0.4 volumes of methylene chloride (each). The combined organics are washed three times with 0.25 volumes of water (each) and dried over 0.025 parts of anhydrous magnesium sulphate. The solvents are 30 removed in vacuum below 85°C. The resulting oil is flashed distilled under vacuum at below 200°C to afford 1-(1',1'-dimethylheptyl)-3,5-dimethoxybenzene (**11**) as an oil.

Step 9: Demethylation of 1-(1',1'-dimethylheptyl)-3,5-dimethoxybenzene with boron tribromide

A solution of **11** in 3 volumes of methylene chloride is added dropwise to a stirred solution of 3 molar equivalents of boron tribromide in 6.7 volumes of methylene chloride, at (-15)- (-

10)^oC over a period of 4-8 hours. The mixture is gradually warmed overnight to room temperature (20-25^oC) and 1 volume of ice water is added. The organic phase is separated and retained and the aqueous phase is extracted twice with 0.3 volumes of methylene chloride. The organics are combined, dried over 0.05 parts anhydrous magnesium sulphate, and the solvent is
5 removed in vacuum below 85^oC. The residue is refluxed with five volumes of hexane, cooled to 20-25^oC and the resulting crystals of dimethylheptyl resorcinol (**12**) filtered off, rinsed with hexane and dried under vacuum at 50-55^oC.

Step 10: Coupling of 4-hydroxy myrtenyl pivalate with 5-(1',1'-dimethylheptyl)-resorcinol

To a mixture of 1.1 molar equivalents of **5** and 1.0 molar equivalent of **12** in 24 volumes of
10 methylene chloride is added four molar equivalents of boron trifluoride etherate, at (-15)-(-10)^oC over one hour. The reaction mixture is maintained at the above temperature for 2.5 hours, then treated with another four molar equivalents of boron trifluoride etherate over one hour and stirred at the same temperature for another 2.5 hours. The reaction mixture is poured onto 0.5 parts of crushed ice containing 29 molar equivalents of sodium bicarbonate and left overnight at
15 20-25^oC. The organic layer is separated and washed 3 times with 1.4 volumes (each) of 5% aqueous solution of sodium bicarbonate and dried over 0.05 parts of anhydrous sodium sulphate. The solvent is removed in vacuum at 50 Torr and 45^oC. The residue is passed through 10 parts of silica gel 60-230 mesh using toluene as eluent. The fractions containing dexanabinol pivalate are collected and the solvent is removed in vacuum to afford dexanabinol pivalate (**13**) as an oil.
20

Step 11: Hydrolysis of dexanabinol pivalate to dexanabinol

To a solution of **13** in 10 volumes of tetrahydrofuran is added 4.3 molar equivalents of 1.0 M lithium aluminium hydride in tetrahydrofuran at (-10)-5^oC over 3-5 hours. The reaction mixture is stirred for one hour at 20-25^oC then cooled to 5^oC and treated dropwise with 0.15 volumes of ethyl acetate, while maintaining the temperature below 5^oC. To the reaction mixture
25 is added 0.5 part crushed ice and 1 part water, and the mixture is acidified to pH 4.0 with about 0.5 volume of acetic acid and then extracted with six times (each) with 0.1 volume of a mixture of hexane: ethyl acetate (2:1). The combined extracts are washed 3 times with 0.25 volumes (each) of water and 3 times with 0.3 volume (each) of 5% aqueous solution of sodium bicarbonate and then dried over 0.5 parts of anhydrous sodium sulphate. The solvent is removed
30 in vacuum at 50 Torr and 40^oC and the residue is recrystallized from 6 volumes of acetonitrile brought to temperature near reflux at 70-81.6^oC. The white crystals of dexanabinol (**14**) are filtered, rinsed with cold acetonitrile (2-8^oC) and dried in a vacuum oven at 60^oC for three hours. The resulting dexanabinol is recrystallized from 28 parts 1:1.2 water:ethanol, filtered, and dried to constant weight at 65-75^oC and 1-5 Torr.

This final crystallization step is crucial for the purity of dexanabinol. Previously disclosed procedures for the synthesis of dexanabinol (US Patent No. 4,876,276) did not teach or suggest the importance of the final crystallization step in achieving the enantiomeric purity required for pharmaceutical or clinical grade material. Moreover, it is now disclosed that the selection of 5 solvent or mother liquor for the final crystallization may affect the purity of the product, as well as the efficiency of the crystallization.

The active pharmaceutical ingredient following crystallization from acetonitrile is superior to that recovered from any previously published procedure, both in terms of enantiomeric purity and overall yield.

10 The process is highly reproducible, as will be shown below, and was performed successfully for the preparation of 100 to 400 grams of dexanabinol. The process was performed under cGMP (current Good Manufacturing Practice) conditions. To the best of our knowledge, dexanabinol was prepared till then in laboratory scale not exceeding few grams and the successful scaling up of the process has important implications regarding the feasibility of the 15 preparation of dexanabinol in scales more appropriate to its clinical testing. The process is now further scaled-up to kilogram quantities to fit commercial production distribution of the drug.

Example 2.

Characterization of dexanabinol enantiomeric purity.

The dexanabinol drug substance must fulfill specifications part of which are listed in Table 20 1. The abbreviations used in this table means: IR infrared, UV ultraviolet, ppm part per million, EU endotoxin unit, CFU colony forming unit, HPLC high pressure liquid chromatography, TLC thin layer chromatography; and the percentages are expressed as weight per weight (w/w).

Unless otherwise stated, the characterization is performed using classical validated analytical methods following established standard operating procedures. When appropriate, 25 samples are compared to reference materials, which are themselves ultrapure standards. HU-211 and HU-210 reference material were prepared by additional crystallization steps and chromatographic separations. Compounds that serve as reference undergo thorough analysis, which includes, on top of the assay listed in Table 1, nuclear magnetic resonance (NMR), Mass spectra (MS) and element analysis. Per definition these ultrapure compounds will be referred to 30 as 100%. The reference material for HU-211 was prepared in-house, while the reference material for HU-210 was purchased from Tocris.

Table 1. Specifications for dexanabinol of high enantiomeric purity.

Test	Specification
Appearance	White to off-white solid
Identification by IR	IR spectrum exhibits maxima and minima at the same wavelengths as the reference material
by UV	UV spectrum exhibits maxima and minima at the same wavelengths as the reference material
HU-211 content (Reversed phase HPLC)	Not less than 98.0%
HU-210 content (Chiral HPLC)	Not more than 0.05%
Melting Point Range	140-143°C
Water	Not more than 0.1%
Loss on Drying	Not more than 0.5%
Specific Rotation	+220±10° (0.1% w/v in chloroform at 25°C, at 589 nm)
Bacterial endotoxins	Not more than 1.5 EU/mg
Total aerobic microbial count	Not more than 10 CFU/g

All clinical grade, intermediate scale, batches of dexanabinol prepared to date were tested for these characteristics and were shown to conform to the specifications. As previously explained one of the most important issues regarding the analysis of dexanabinol is the content of the psychoactive enantiomer HU-210. The determination of the chiral purity is performed using HPLC methodology modified from Levin et al. (Levin S. et al., J. Chromatography A, 654: 53-64, 1993). Briefly, one set of calibration standard solutions was prepared using the HU-211 and HU-210 reference material diluted into HPLC mobile phase to yield standards of 1 to 50 µg/ml. Similarly, the sample was dissolved into the mobile phase to yield a solution of 5 mg/ml. The mobile phase is composed of 96% volume/volume (v/v) of n-hexane and 4% v/v of isopropanol, each HPLC grade and previously filtered through a 0.45 µm nylon membrane, the mixture was degassed using a sonication bath for a few seconds. The HPLC is performed on a chemically modified amylose-based chiral column ChiralPak AD-H, 250x4.6 mm, 5 µm particle size (Daicel Ltd). The chiral stationary phase is a tris(3,5-dimethylphenylcarbamate) derivative of amylose immobilized on macroporous silica gel. The flow rate is 1 ml per minute, the chromatography is performed at ambient temperature of about 25°C and the detection is performed at 215 nm. The controls or samples are injected at a volume of 40 µl and a run is

performed for 30 minutes. The HPLC mobile phase is injected first as a blank, then the 50 µg/ml standard of HU-210 mixed with HU-211 to determine the retention time for each enantiomer and confirm the separation of the peaks and thus the efficiency of the analytical method. HU-210 elutes after HU-211 with a typical relative retention time of about 1.4. Then the 1 to 10 µg/ml calibration solutions are injected and a regression analysis on the response peak versus concentration is performed, the correlation coefficient R-square must be above 0.98. The sample, prepared in duplicates, is then injected and the analyte peak is integrated and the concentration of the HU-210 impurity is determined from the calibration curve. If no HU-210 is detectable a confirmation sample is prepared where the sample is spiked with 0.1% HU-210 to confirm the expected location of the enantiomer on the chromatogram. This method was thoroughly validated for selectivity, precision, linearity, accuracy and robustness. There is no interference with sample blank or with dexanabinol related compounds, such as dexanabinol pivalate (13 in Scheme 5). Quantitation of HU-210 is linear at least within the range of 0.0025 up to 0.12% w/w of dexanabinol. The detection and quantitation limits of HU-210 are respectively 0.00125 and 0.0025% w/w of dexanabinol. The method is highly repeatable as measured by low relative standard deviation (RSD) when the same sample is injected six times (system repeatability RSD < 2%), when six replicates are injected (method repeatability RSD < 7%) and when 6 replicates are tested on two HPLC systems (intermediate precision ~ 5%). This method allows to determine the level of HU-210 in the dexanabinol drug substance sample with accuracy and thus the level of enantiomeric purity of HU-211, as expressed as enantiomeric excess over HU-210, with confidence.

Similarly, the amount of HU-211 in dexanabinol drug substance is assayed by reversed phase (RP)-HPLC. The HPLC column used is a Hypersil BDS RP-18 3 µm, 150x4.6 mm, maintained at 30°C. The mobile phase is composed of 60% Acetonitrile and 40% 10 mM ammonium acetate buffer pH 5.2. The injection volume is 15 µl, the flow rate is 1.2 ml per minute, detection is performed at 280 nm and a run lasts 45 minutes. Sample or HU-211 reference standard are dissolved in acetonitrile, mixed by vortex and sonicated to complete dissolution to yield solutions of 1 mg/ml. Acetonitrile is injected as blank, followed by five injections of the standard solution to ensure that the RSD is below 2.0%. The retention time of dexanabinol is about 23 minutes under those conditions. The sample to be assayed is prepared in duplicate and is then injected. The percent of HU-211 is then calculated using the following formula %HU-211= $(R_U/R_S) \times (W_S/V_S) \times (V_U/W_U) \times 100$, wherein R_U and R_S are the peak responses of the unknown sample and standard respectively, W_U and W_S are the weights (in mg) and V_U and V_S are the volumes (in ml) of the unknown sample and standard respectively.

Using the above-described methods for quantitation of HU-210 and HU-211, the enantiomeric excess of dexanabinol was determined in four clinical grade batches of the drug substance. These batches of active pharmaceutical ingredient (API) were later used for the preparation of drug product as used in the clinical trials. Chromatograms of the HPLC analysis 5 are displayed in Figure 1. All other parameters were found conform to specifications and met the acceptance criteria. The results regarding the enantiomeric purity are shown in Table 2.

Table 2. Contents of HU-211 and HU-210 in four clinical trial batches.

Batch	Amount (g)	HU-211 (% w/w)	HU-210 (% w/w)	Enantiomeric excess (%)
AC8003HU	103	98.8	0.0160	99.968
AC9001HU	235	98.8	0.0036	99.993
AC0006HU	213	98.7	0.0079	99.984
AC1010HU	392	99.1	0.0025	99.995

It can be deduced from Table 2, that the synthetic procedure previously described is suitable for the preparation of clinical grade batches of dexanabinol of very high enantiomeric 10 purity as expressed by an enantiomeric excess of at least 99.90%.

Example 3.

Formulation of dexanabinol of high enantiomeric purity for clinical use.

Dexanabinol is an extremely lipophilic compound with a computed Log P of 7.69 (Advanced Chemistry Development, software Ver. 4, by ACD labs.) and an experimental Log P 15 of 7.44 (Thomas B.F. et.al., J. Pharmacol. Exp. Ther. 255: 624-30, 1990) rendering it essentially insoluble in water (calculated water solubility 0.1 ng/ml). Though dexanabinol can be formulated in a variety of compositions that accommodate its lipophilic nature, the clinical trials are performed with the drug substance in the following formulation wherein all ingredients are of pharmacopeial grade. Dexanabinol drug substance is formulated as a 5% w/v concentrate in a 20 cosolvent vehicle composed of CREMOPHOR EL® (polyoxyl 35 castor oil; 65% w/v) and absolute ethanol (26.5% w/v). The dexanabinol cosolvent concentrate also contains 0.01% w/v Edetic acid and 0.5% w/v Vitamin E (DL- α -tocopherol) as antioxidants. This parenteral 5% cosolvent solution is a clear, slightly yellow, sterile and pyrogen-free concentrate of dexanabinol for injection which must be diluted prior to intravenous infusion 1/20 to 1/100 with sterile 0.9% 25 sodium chloride solution for injection. The drug product is preservative-free and sterilization is achieved via a sterile filtration and aseptic processing technology. The quantitative composition

of the 5% dexanabinol parenteral cosolvent concentrate is given in Table 3. The dexanabinol drug substance is manufactured as previously described in example 1 and according to the specifications above-mentioned in example 2, specifically in enantiomeric excess of at least 99.90%. All the inactive ingredients used, ethanol absolute, Edetic acid, Vitamin E and 5 CREMOPHOR EL[®], are manufactured according to standards set in the British Pharmacopea, United States Pharmacopea or European Pharmacopea, all being considered acceptable.

Table 3. Composition of dexanabinol parenteral concentrate.

Ingredient	mg/ml	mg/g
Dexanabinol	50.0	51.5
Ethanol Absolute	265.0	273.2
CREMOPHOR EL [®]	650.0	670.0
Edetic Acid	0.1	0.1
Vitamin E	5.0	5.2

As previously stated the parenteral concentrate formulation has to be diluted prior administration. In a stability study, the above-described clinical formulation of dexanabinol of 10 high enantiomeric purity was diluted with sterile 0.9% sodium chloride solution for injection at a ratio of 1:5 up to 1:500. The ready for injection diluted drug concentrate were stable at all dilution ratios for up to 24 hours as determined by HPLC analysis performed on filtrates collected at predetermined time points along the duration of the study.

Example 4.

15 **Other pharmaceutical compositions for dexanabinol of high enantiomeric purity.**

The above described pharmaceutical composition in use in clinical trial for dexanabinol of high enantiomeric purity has been selected following intensive formulation development. It is well known that cosolvents are employed in various FDA approved parenteral products. Drugs dissolved in these cosolvents are usually prepared as concentrated solutions that are diluted with 20 sterile sodium chloride or dextrose solutions before injection. A variety of non-aqueous vehicles have been used successfully as cosolvents for the solubilization and intravenous delivery of many poorly soluble drugs. A survey of FDA-approved parenteral products shows five water-miscible cosolvents as components of sterile formulations: glycerin, ethanol, propylene glycol (PG), polyethylene glycol(PEG), and dimethylacetamide. Other non-aqueous vehicles include 25 surface-active agents such as TWEEN[®] 80 and CREMOPHOR EL[®]. Surfactant agents are

usually incorporated into parenteral preparations to provide an increase in drug solubility through micellization and to prevent drug precipitation upon dilution. The vehicle of choice should provide for adequate stability, have an acceptable safety profile and allow for drug administration within the shortest period of time leading to the highest possible plasma concentration Cmax thereby providing for the maximum achievable therapeutic drug concentrations in the target organ with minimal administration risks.

Cosolvent formulations.

The goal of this study was to find a suitable cosolvent formulation for a concentrate of dexamabinol of high enantiomeric purity to be diluted with sterile saline solution before injection.

10 The compositions of the cosolvent concentrate formulations tested are presented in Table 4. All formulations contained 1% dexamabinol and compositions of FDA-approved cosolvent vehicles. The concentrations of the various ingredients are expressed as % weight/weight.

Table 4. Compositions of various cosolvent formulations.

Formulation Number	CREMOPHOR EL®	PEG 300	Ethanol	TWEEN® 80	Benzyl Alcohol	PG	H ₂ O	Drug dissolution
SA 46-4		65	24	8	3			soluble
SA 46-5		66	26	8				soluble
SA 46-13				4		20	76	insoluble
SA 46-14-1		50					50	insoluble
SA 46-14-3	11.5						88.5	insoluble
SA 46-15-1	7						93	insoluble
SA 46-15-2	70		30					soluble
ED 61 48-1			10			40	50	insoluble

As can be seen from Table 4, only anhydrous formulations SA 46-4, SA 46-5 and SA 46-15-2 containing surfactants (TWEEN® 80 or CREMOPHOR EL®) were able to dissolve dexamabinol of high enantiomeric purity. In cosolvent mixtures containing water, the drug was insoluble, but aqueous cosolvents are certainly appropriate for less lipophilic prodrugs, salts or esters of dexamabinol.

CREMOPHOR EL®:ethanol formulations.

Once it was established that a cosolvent formulation made of CREMOPHOR EL® (polyoxyl 35 castor oil) and ethanol is appropriate to dissolve the drug, a matrix of such formulations was prepared at various concentrations (from 30 to 70% w/w of each ingredient) and with increasing amounts of dexamabinol of high enantiomeric purity (20, 50 and 100 mg/ml).

The exact composition of these formulations is described in the left hand side of Table 5. The drug cosolvent concentrates were diluted at various ratios in saline and the stability of the drug in the resulting solutions was monitored for 24 hours. The results are detailed in the right hand side of Table 5.

5 Table 5. Compositions and post-dilution stability of CREMOPHOR EL[®]:ethanol formulations.

Cosolvent Composition			Stability following dilution in saline		
Dexanabinol (mg/ml)	% CREMOPHOR EL [®]	% Ethanol	Dilution 1/5	Dilution 1/10	Dilution 1/20
20	70	30	Stable	Stable	Stable
	50	50	Stable	Stable	Stable
	30	70	Stable	Stable	Stable
50	70	30	Stable at least 7 hours	Stable at least 7 hours	Stable at least 7 hours
	50	50	Stable at least 7 hours	Stable at least 4 hours	Stable at least 7 hours
	30	70	Crystals appeared at 2 hours	Crystals appeared at 2 hours	Crystals appeared at 2.5 hours
100	70	30	Crystals appeared at 2 hours	Crystals appeared at 2 hours	Crystals appeared at 3.5 hours
	50	50	Crystals appeared at 1.5 hours	Crystals appeared at 1.5 hours	Crystals appeared at 1.5 hours
	30	70	Crystals appeared at 45 minutes	Crystals appeared at 55 minutes	Crystals appeared at 1.5 hours

The results obtained with these nine formulations showed that CREMOPHOR EL[®]:ethanol cosolvent formulations were able to successfully dissolve up to at least 100 mg/ml of dexanabinol of high enantiomeric purity. The higher the amount of CREMOPHOR EL[®] the more stable the drug after dilution of the cosolvent concentrate into aqueous solutions. The 70:30
10 CREMOPHOR EL[®]:ethanol formulation was selected as a basis for further optimization. Having the clinical application in mind where the cosolvent concentrate is diluted in physiological buffer immediately prior to injection, the 50 mg/ml dose was selected for further studies since at this concentration the diluted drug is stable for at least seven hours and the concentration allows for the injection over a short period of time. The selected formulation of 50 mg/ml dexanabinol of
15 high enantiomeric purity dissolved in 70:30 CREMOPHOR EL[®]:ethanol was stable after

dilution with saline at all ratios tested from 1:5 to 1:20. A dilution of 1:5 is about the minimum required prior to injection, since it is recommended not to inject solutions containing more than 10% ethanol. As already noted the final clinical formulation was shown to be stable for 24 hours in dilutions from 1:5 up to 1:500.

5 **Example 5.**

Pharmacokinetic studies performed with dexanabinol of high enantiomeric purity.

The pharmacokinetics of dexanabinol of high enantiomeric purity formulated in CREMOPHOR EL[®]:ethanol as described in example 3 were investigated in rats, rabbits, and monkeys following intravenous administration of single doses, and 14 and 28 days of repeated dosing. Human pharmacokinetics was studied during Phase I and Phase II clinical studies. Dexanabinol used in the pharmacokinetic studies was formulated as drug concentrates of 50 and 100 mg/ml and diluted with sterile 0.9% NaCl solution prior to intravenous (i.v.) administration to the desired final doses. Determination of dexanabinol concentrations in plasma and brain extracts was carried out using a validated Gas Chromatography-Mass Spectra (GC-MS) assay following solid phase extraction of the drug and derivatization. The limit of quantitation of the assay is 0.1 ng/ml.

Pharmacokinetic parameters were estimated by a non-compartmental method using WinNonlin Professional version 3.2 (Pharsight Corp., Mountain View, CA). The maximum plasma concentration (Cmax), when the drug is administered by infusion, is the concentration at the end of infusion. The Cmax following intravenous bolus administration is the value estimated by the software to be the concentration at t=0. The terminal slope (λ) was estimated by linear regression through the last time points and used to calculate the terminal half-life ($t_{1/2}$) from the following equation:

$$t_{1/2} = 0.693 / \lambda$$

25 The area under the curve from time of dosing through the last time point (AUC_z) was calculated by the linear trapezoid method. The AUC extrapolated to infinity (AUC_∞) was calculated from the following equation:

$$AUC_{\infty} = AUC_z + C_z / \lambda$$

where C_z is the concentration at the last time point predicted by the linear regression. AUC_∞ was 30 normalized for dose (mg/kg) and presented as AUC_∞/Dose. Mean residence time (MRT), when the drug is administered by infusion is described by the following equation:

$$MRT = (AUMC/AUC) - (TI)/2$$

Mean residence time after i.v. bolus administration is described by the following equation:

$$MRT = (AUMC/AUC)$$

where AUMC is the area under the first moment curve and TI is the length of infusion. Plasma clearance (CL), and the apparent volume of distribution at steady state (V_{ss}) were calculated from the following equations:

$$CL = \text{Dose} / AUC_{\infty}$$

5 $V_{ss} = MRT \times CL$

Brain pharmacokinetic parameters in animal studies were estimated by non-compartmental methods similar to those used for plasma data with the addition of an estimate of the time of maximum concentration (Tmax) which was assumed to be zero for the plasma data. Cmax is the concentration corresponding to Tmax. AUC_z and AUC_{∞} were calculated as described above.

- 10 Kp, brain-to-plasma partition coefficient, was determined by means of the area method and using the equation:

$$K_p = AUC_{\infty} \text{ brain} / AUC_{\infty} \text{ plasma}$$

The percentage of oral bioavailability was calculated using the following equation:

$$\%F = [AUC_{\text{oral}}/\text{Dose}_{\text{oral}}] / [AUC_{\text{IV}}/\text{Dose}_{\text{IV}}]$$

15 Non-human pharmacokinetic studies.

In order to support the i.v. testing of dexanabinol of high enantiomeric purity in humans, a series of acute single-dose and sub-chronic multiple dose toxicology studies were conducted to establish the safety profile of the compound in rats, rabbits, and monkeys. The 2-week and 4-week multidose studies included complete clinical and morphological evaluations. In vitro/in vivo mutagenicity studies and special toxicological evaluations have also been carried out to evaluate the safety profile of dexanabinol. The toxicology studies employed doses that were multiples of the proposed clinical doses. The results of the toxicological studies performed with dexanabinol of high enantiomeric purity indicate that the drug when formulated in CREMOPHOR EL[®]:ethanol as described in example 3 is generally well tolerated following 25 single and/or multiple i.v. doses in rats, rabbits and monkeys.

Single dose toxicity studies showed a no observed adverse effect level (NOAEL) of 50 mg/kg in Sprague Dawley rats, 25 mg/kg in New Zealand White rabbits, and 50 mg/kg in Cynomolgus monkeys. Table 6 summarizes the maximum plasma concentration (Cmax) and the area under the plasma concentration versus time curve (AUC) observed at the NOAEL doses 30 cited above, as well as the animal to human exposure ratios (ER) for dexanabinol of high enantiomeric purity, expressed as the ratio of the pharmacokinetic (PK) parameter to that observed for a 150 mg dose in a Phase I study in human volunteers and in Phase II study in patients suffering from severe traumatic brain injury (TBI). The details regarding the human Phase I and Phase II studies have been described (Brewster M. E. et al., International Journal Of

Clinical Pharmacology and Therapeutics 35: 361-5, 1997; Knoller N. et al., Crit. Care Med. 30: 548-54, 2002). The results are included in the following table for the sake of comparison. In animals, it did appear that clearance was faster in male rats than in females; however, this observation was not replicated in rabbits or monkeys. Both Cmax and AUC in rats, rabbits, and 5 monkeys administered a single dose of dexanabinol at the above NOAELs were well above those observed in the clinical studies.

Table 6. PK and ER across species, following single i.v. administration of dexanabinol.

Study	Dose	Cmax (ng/ml)	Ratio to Phase I	Ratio to Phase II	AUC_∞ (ng x min/ml)	Ratio to Phase I
Rat	50 mg/kg					
Male		102,076	20.4	51.9	4,049,849	21.0
Female		38,774	7.7	19.7	10,391,118	54.0
Rabbit	25 mg/kg					
Male		33,797	6.8	17.2	1,206,621	6.3
Female		34,544	6.9	17.6	973,407	5.1
Male & Female		33,353	6.7	17.0	1,090,290	5.7
Monkey	50 mg/kg					
Male		166,992 ± 20,569	33.4	84.9	7,040,626 ± 1,785,043	36.6
Female		175,029 ± 38,333	35.0	89.0	8,169,666 ± 2,867,106	42.4
Male & Female		171,010 ± 17,911	34.2	86.9	7,605,146 ± 1,416,806	39.5
Phase I	150 mg	5,006 ± 434	1	NA	192,547 ± 9,283	1
Phase II	150 mg	1,967 ± 253	NA	1	89,019 ± 8,320	NA

In 14-day multiple dose pharmacokinetic studies, the NOAEL was 15 mg/kg/day in rats and 25 mg/kg/day in rabbits. In a 28-day study in monkeys the NOAEL was 25 mg/kg/day.

10 Cmax and AUC observed following the last dose at the NOAEL in the multiple dose toxicity studies and the ratios of these values to those observed in the Phase I and II studies for the 150 mg dose are shown in Table 7. Exposure levels as exhibited by the AUC_∞ associated with the NOAEL in the 14-day studies and 28-day study far exceed those observed in the clinical studies.

Table 7. PK and ER across species, following final dose in multiple i.v. administration of dexamabinol.

Study	Dose /Day	Cmax (ng/ml)	Ratio to Phase I	Ratio to Phase II	AUC _∞ (ng x min/ml)	Ratio to Phase I	Ratio to Phase II
Rat	15 mg/kg Day 14						
Male		30,221	6.0	15.4	1,962,884	10.2	22.1
Female		17,396	3.5	8.8	3,516,133	18.3	39.5
Rabbit	25 mg/kg Day 14						
Male		149,556	29.9	76.0	4,061,193	21.1	45.6
Female		115,281	23.0	58.6	4,076,845	21.2	45.8
Male & Female		132,117	26.4	67.2	4,059,030	21.1	45.6
Monkey	25 mg/kg Day 28						
Male		163,346 ± 13,994	32.6	83.0	12,497,536 ± 1,587,369	64.9	140.4
Female		161,172 ± 6,403	32.2	81.9	10,679,654 ± 249,177	55.5	120.0
Male & Female		162,259 ± 7,136	32.4	82.5	11,588,595 ± 819,313	60.2	130.2

The NOAELs compared above are based upon 2 weeks and 4 weeks of daily dosing whereas the anticipated clinical regimen consists of a single dose. It is, therefore, reasonable to 5 assume that the NOAELs defined in the multiple-dose animal studies represent an even greater multiple of the human dose if cumulative exposure is considered.

The plasma concentration versus time profiles following the final administration at the NOAEL dose levels in the repeat dose studies in animals are shown in Figure 2 along with the profile obtained in humans from the Phase I and Phase II studies, that will be described below. 10 The pharmacokinetic profile in all species demonstrated an initial rapid decrease in plasma related concentrations, a common characteristic of highly lipophilic compounds, followed by a slower decline. Plasma concentrations were still detectable, but low, 24 hours after injection, suggesting there might be some accumulation in the repeated dose studies. While there was some evidence for accumulation in the plasma with repeated dosing, the extent of accumulation 15 was minimal.

The target organ for dexamabinol therapeutic intervention in patients suffering from TBI being the brain, the monitoring of dexamabinol level in the brain was included in the rat study.

Sprague Dawley rats of each sex received a bolus intravenous injection of 4 mg/kg of dexanabinol of high enantiomeric purity in the CREMOPHOR EL®:ethanol clinical formulation. The animals were divided into eight sub-groups of 6 animals, 3 male and 3 female, assigned to a single bleeding time point. The eight bleeding time points were 5, 15, 30 minutes and 1, 2, 4, 8 and 24 hours after injection. Following bleeding the animals were euthanized and their brain were removed for analysis of brain dexanabinol concentrations. The mean rat plasma or brain concentrations of dexanabinol differed between male and female, thus the pharmacokinetic parameters were calculated separately for each gender. The divergences between genders were more pronounced in plasma, reaching 2-3 fold differences for some pharmacokinetic parameters,
5 than in brain, where the differences are not statistically significant for most time points. The results for male and female were averaged in order to compare the levels of dexanabinol in plasma versus brain, following single injection of 4 mg/kg dexanabinol. The results are depicted in Figure 3. Unlike plasma concentrations, which peaked at the earliest measured time point and rapidly decline in the initial phase, the brain concentrations equilibrated with plasma
10 concentration about 30 minutes after injection. Brain level of dexanabinol continued to increase and displayed a broader peak until levels slowly declined.
15

Taken together these studies show that the CREMOPHOR EL®:ethanol clinical formulation is efficient for the safe delivery of dexanabinol both into plasma and into the target organ, the brain. The use of dexanabinol of high enantiomeric purity at dose tested caused no
20 psychomimetic side effect in any of the animal species tested.

Human Pharmacokinetic Studies

Following the above-described studies in animals, which demonstrated the safety and the pharmacokinetic profile of the drug, dexanabinol of high enantiomeric purity was then administered to human subjects. According to standard regulatory procedures dexanabinol was
25 first tested in healthy subjects during two Phase I studies, and once its safety was confirmed in humans it was administered to traumatic brain injury patients during a Phase II clinical study.

A-Phase I, open label, single center study was conducted to evaluate the safety and tolerance of dexanabinol of high enantiomeric purity following a single intravenous administration to normal, healthy male volunteers (Brewster M. E. et al., International Journal Of
30 Clinical Pharmacology and Therapeutics 35: 361-5, 1997). The trial was designed as a rising-dose tolerance study in healthy young male volunteers. In the study, seven groups of at least six subjects each (in the 100 mg dose n=9) received increasing doses (4, 8, 16, 32, 48, 100, 200 mg/volunteer) of dexanabinol. An additional group of 6 subjects received the vehicle alone. The lower doses, from 4 to 32 mg/volunteer, were included only in the safety segment of the study.

Volunteers were followed-up up to 6 days after drug dosing for safety evaluation. Drug administration was well tolerated with no medically important drug-related findings. The conclusions of this safety study were that dexamabinol administered acutely at doses up to and including 200 mg per subject was safe and did not lead to any substantial discomfort to treated subjects.

The pharmacokinetic segment of this study involved 27 healthy male subjects to assess the pharmacokinetics profile of 48, 100 and 200 mg i.v. doses of dexamabinol. Each dosing group, including vehicle control, consisted of 6 healthy male subjects, except for the 100 mg dosing group which contained nine subjects. On the prestudy day, volunteers were treated with 20 mg dexamethasone orally. On the study day, each group was premedicated with Chlorpheniramine maleate 10 mg (H_1 blocker) and Cimetidine 300 mg (H_2 blocker) intravenously, followed 30 minutes later by a single intravenous infusion of dexamabinol, administered using an Ivac peristaltic pump at a rate of 6 ml/min (approximately 15 min infusion/dose). Ten milliliters of blood were then removed (from the contralateral arm) at the end of the infusion, at 5, 10, 20, 30, 45 min, and at 1, 2, 3, 6, 12 and 24 hr post infusion. In some cases blood was also drawn 48 hr post end of infusion.

Mean plasma dexamabinol concentrations, as determined by validated GC/MS/MS analysis, show that for all dose levels, there was an initial rapid decline in plasma concentration followed by a progressively slower decline. Dexamabinol manifested a rapid distributional phase half-life of 2-3 minutes, an intermediate phase elimination half-life of 1-2 hours and a terminal elimination phase half-life of 8.5-9.5 hours. Mean pharmacokinetic parameters were estimated by non-compartmental methods up to 24 hr post-infusion for each dose group (mean \pm SE; n=6 or 9) using WinNonlin Professional version 3.2, (Pharsight Corp., Mountain view CA) and are presented in Table 8.

Table 8. Pharmacokinetic analysis of dexamabinol in healthy volunteers (1st Phase I study).

Dose (mg)	C _{max} (ng/ml)	AUC _z (ng x min/ml)	AUC _∞ (ng x min/ml)	AUC _∞ / Dose (ng x min/ml)	CL (ml/min/kg)	t _{1/2} (hr)	MRT (hr)	V _{ss} (l/kg)
48	1,856 \pm 371	42,610 \pm 4,410	43,479 \pm 4,453	72,469 \pm 8,774	14.9 \pm 1.9	6.3 \pm 0.7	3.1 \pm 0.2	2.8 \pm 0.4
100	2,891 \pm 434	71,831 \pm 5,789	73,281 \pm 5,773	59,374 \pm 4,742	17.8 \pm 1.5	6.1 \pm 0.7	3.1 \pm 0.3	3.4 \pm 0.4
200	4,572 \pm 737	134,204 \pm 6,660	139,207 \pm 6,131	48,162 \pm 3,355	21.3 \pm 1.6	8.2 \pm 0.7	4.0 \pm 0.6	5.0 \pm 0.7

Plasma concentrations were approximately 1.8 µg/ml after a 48 mg dose (0.62 mg/kg), 2.9 µg/ml at 100 mg (1.29 mg/kg), and 4.6 µg/ml at 200 mg (2.59 mg/kg). The total areas under the plasma concentration curve (AUC_{∞}) differed significantly for each dose group and were linearly related to the dose. Total plasma clearance (CL) values of dexamabinol and V_{ss} values increased with the dose, and the AUC_{∞} values normalized for dose ($AUC_{\infty}/Dose$) decreased with the dose. Since CL, V_{ss} are by definition dose-dependent pharmacokinetic parameters (CL = Dose/ AUC_{∞} and $V_{ss} = MRT \times CL$), their increase with dose elevation could be explained by some under-dosing for the higher doses that will result in overestimation of CL and V_{ss} and under estimation of $AUC_{\infty}/Dose$. Simulations of representative dosing solution preparation by dilutions of dexamabinol concentrate (50 mg/ml), indicated that the 100 mg group was under-dosed by approximately 10% and the 200 mg group was under-dosed by approximately 20%. Compensating for this under-dosing, the overestimated values of CL and V_{ss} are reduced to statistically non-significant differences across the dose groups ($p>0.5$ for CL and $p>0.2$ for V_{ss}), and $AUC_{\infty}/Dose$ underestimated values increase to statistically non-significant differences across the dose groups ($p>0.5$).

A second human Phase I study involving 24 healthy male volunteers was carried out to compare the pharmacokinetics of dexamabinol following a single i.v. dose of 48 mg or 150 mg. The subjects were divided into two groups of 12 subjects each. Each group was premedicated with ATOSIL® 25 mg (Promethazine H1 blocker), and ZANTIC® 50 mg (Ranitidine H2 blocker) intravenously, followed 15 minutes later by a single short intravenous infusion of dexamabinol lasting 15 minutes. Blood samples for pharmacokinetic assays for dexamabinol were collected immediately before premedication ($T=0$), immediately after dosing ($T=0+$) (at the end of the infusion), at 5, 10, 20, 30, 45, and 60 min, and 2, 4, 6, 8, 12, 16, 24, 48, 72 and 96 hr post-dosing. Blood was also collected from four subjects from group 2 (150 mg/kg) on Days 6, 10 and 14. For both dose levels, initial rapid declines in plasma concentration followed by a progressively slower decline were observed.

Pharmacokinetic parameters were estimated by non-compartmental methods up to 96 hr post-infusion, using WinNonlin Professional version 3.2 (Pharsight Corp., Mountain View, CA, USA). The estimated pharmacokinetic parameters (mean ± SE) are shown in Table 9.

Table 9. Pharmacokinetic analysis of dexanabinol in healthy volunteers (2nd Phase I study).

Dose (mg)	C _{max} (ng/ml)	AUC _z (ng x min/ml)	AUC _∞ (ng x min/ml)	AUC _∞ / Dose (ng x min/ml)	CL (ml/min/kg)	t _{1/2} (hr)	MRT (hr)	V _{ss} (l/kg)
48	1,226 ± 118	48,673 ± 2,361	49,467 ± 2,399	78,137 ± 4,305	13.2 ± 0.7	31.2 ± 3.6	8.4 ± 0.5	6.6 ± 0.5
150	5,006 ± 434	190,806 ± 9,173	192,547 ± 9,283	93,408 ± 4,224	10.9 ± 0.5	23.4 ± 1.8	6.9 ± 0.4	4.5 ± 0.4

Intravenous administration of dexanabinol generated high initial plasma levels of the drug (as reflected by values obtained at the end of the drug infusion) that were dose-related. Maximum plasma concentrations (C_{max}) were 1.23 µg/ml after the 48 mg dose (0.63 mg/kg), 5 and 5 µg/ml at 150 mg (2.05 mg/kg). In both cases, the drug levels fell rapidly as a function of time with 30 min values being about 11% of the end of infusion levels. The total areas under the plasma concentration curve (AUC) differed significantly for each dose group and increased proportionally to the dose. Total plasma clearance (CL) values of dexanabinol were similar for both dose groups and averaged 12 ml/min/kg across the two dose groups. While 10 pharmacologically, dexanabinol bears little resemblance to naturally occurring cannabinoids, its pharmacokinetic properties are similar to those of Δ⁹-THC and related materials. These properties include rapid initial distribution, long terminal elimination half-life, a rapid total plasma clearance and a large volume of distribution. Altogether, these parameters ensure 15 extensive uptake of the drug into tissues, including the brain and central nervous system, and rapid manifestation of biological action. Beside gathering the pharmacokinetic parameters above described, the two phase I studies allowed to determine that using dexanabinol of high enantiomeric purity in human subjects was safe, well tolerated and no psychomimetic side effects were detected.

The acute nature of events in traumatic brain injury defines a relatively narrow time window for medical intervention, making it scientifically reasonable to assume that the attainment of high peak plasma levels of the drug (C_{max}) as soon as possible is essential for achieving the high brain drug concentrations necessary for optimal therapeutic activity. Moreover, since dexanabinol is a very lipophilic compound (log P of 7.44), it will cross the blood-brain barrier easily by diffusion, thereby, brain and plasma concentrations will tend to 20 equilibrate fairly quickly. Therefore, higher blood levels will translate into higher brain levels more readily than if some active transport process was involved or if the process was slow and required a long duration of high plasma concentrations. In addition, since dexanabinol is a non- 25

competitive antagonist of the NMDA receptor the faster the administration, the quicker the receptors are saturated and the sooner the pharmacological effect is established.

A Phase II, double masked, multi-center study was conducted to evaluate the safety and tolerance of dexanabinol of high enantiomeric purity following a single intravenous administration in patients with severe head trauma (Knoller N. et al., Crit. Care Med. 30: 548-54, 2002). Treatment was administered within 6 hours of injury, based on the therapeutic window observed in relevant animal models. Additional objectives of the study were to evaluate the long-term outcome of the patients and to determine the optimal dose for Phase III studies. Medical information was collected en route or upon arrival at the hospital to determine a patient's suitability for enrollment and a randomized patient number was assigned. Written informed consent was obtained from relatives, all eligible patients being in coma. Antihistamines (PHENERGAN® 25 mg and Cimetidine 50 mg) were administered by intravenous bolus injection 15 minutes prior to study drug administration. Dexanabinol was manufactured and formulated as previously described (50 mg/ml in CREMOPHOR EL®:ethanol clinical formulation) and diluted into 100 ml saline prior to injection. Solutions of dexanabinol were infused intravenously using a peristaltic pump (Ivac) at a rate of 6 ml/min (or approximately 15 min/dose). The total doses of dexanabinol scheduled to be administered were 48, 150, or 200 mg per patient. Five milliliters of blood were removed (from the contralateral arm) at the end of the infusion, at 10 and 30 min, and at 1, 3, 6, 12, and 24 hours thereafter for determination of plasma dexanabinol concentrations. Pharmacokinetic parameters were estimated by non-compartmental methods (WinNonlin Professional version 3.2) up to 24 hr post-injection. The estimated pharmacokinetic parameters (mean ± SE) are presented in Table 10.

Table 10. Pharmacokinetic analysis of dexanabinol in severe TBI patients (Phase II study).

Dose (mg)	C _{max} (ng/ml)	AUC _z (ng x min/ml)	AUC _∞ (ng x min/ml)	AUC _∞ / Dose (ng x min/ml)	CL (ml/min/kg)	t _{1/2} (hr)	MRT (hr)	V _{ss} (l/kg)
48 (n=10)	1,150 ± 226	32,889 ± 4,294	34,341 ± 4,383	51,846 ± 5,526	22.6 ± 3.9	7.0 ± 0.9	4.1 ± 0.7	6.6 ± 2.6
150 (n=20)	1,967 ± 253	87,166 ± 8,301	89,019 ± 8,320	43,542 ± 4,329	31.0 ± 5.8	5.3 ± 0.5	3.8 ± 0.4	7.5 ± 1.5
200 (n=21)	5,793 ± 835	190,449 ± 14,268	195,116 ± 14,381	69,007 ± 5,835	17.6 ± 1.9	6.3 ± 0.3	3.5 ± 0.3	4.2 ± 0.9

Pharmacokinetic parameters are generally dose proportional. C_{max} is somewhat lower, and the dose-dependent pharmacokinetic parameters clearance (CL) and volume of distribution at steady-state (V_{ss}) are somewhat higher, at the 150 mg dose level than would be expected based

on the values obtained at the higher and lower doses. This is most likely the result of under-dosing of the 150 mg group. Under-dosing would also lead to under-estimation of the dose-normalized AUC value (AUC/D) which indeed is lower for the 150 mg dose than for the low and high doses. Simulations of the dosing solution preparation indicated that the 150 mg group was
5 under-dosed by approximately 20% while the 48 and 200 mg groups were within 10% of the target dose. Compensating for this under-dosing would reduce the estimated values of CL and V_{ss} by approximately 20% in the mid dose group. The pharmacokinetic profiles for the three doses, tested in the phase II study are similar to those obtained in the previous phase I studies, specifically there is an initial rapid decrease followed by a slower decline in plasma
10 concentrations.

The primary goal of this study was to establish the safety of dexanabinol of high enantiomeric purity in severe head trauma patients, and indeed dexanabinol was safe and well tolerated in severe head injury. Primary end points included intracranial pressure (ICP), cardiovascular function (heart rate, mean arterial blood pressure, cerebral perfusion pressure and
15 electrocardiogram), clinical laboratory tests, and adverse medical events. The clinical outcome was assessed by the Glasgow outcome scale throughout a six month follow-up period. The nature and incidence of adverse medical events were similar in all groups supporting the safety of dexanabinol of high enantiomeric purity. Moreover, the treated patients achieved significantly better intracranial pressure/cerebral perfusion pressure control without jeopardizing blood
20 pressure. A trend toward faster and better neurologic outcome was also observed. Dexanabinol is currently being tested in a Phase III clinical trial for TBI.

As of this date, more than 500 patients have been exposed in International clinical trials to dexanabinol of high enantiomeric purity, and no serious adverse reactions were reported demonstrating the clinical safety of dexanabinol CREMOPHOR EL®:ethanol product without
25 any psychotropic activity or cannabinomimetic adverse effects. A Safety Committee appointed to monitor patient data to ensure patient safety analyzed patients' data after the enrollment and in all cases the safety committee found the drug safe.

Example 6.

Other routes of delivery for dexanabinol of high enantiomeric purity.

30 The route of delivery chosen in the clinical studies was the intravenous route, which is appropriate for rapid drug delivery to the systemic circulation and to target organs in hospital setting in case of acute indications such as TBI. While the preferred route of delivery described for the CREMOPHOR EL®:ethanol clinical formulation is intravenous, it is possible to use this formulation for intraperitoneal (i.p.), intramuscular (i.m.), subcutaneous (s.c.), i.c.v., intrathecal

and per os administration. For chronic indications other routes can also be used for the delivery of dexamabinol of high enantiomeric purity. These additional routes of administration will also demonstrate the feasibility of further formulations to efficiently deliver dexamabinol.

Oral delivery

- 5 Dexamabinol of high enantiomeric purity (lot # AC9001HU) filled in hard gelatin capsules have shown good oral bioavailability. A pharmacokinetic study for oral bioavailability of dexamabinol in large animals using the minipig model (the best animal model for oral absorption of drugs) was carried out. The animals (n=3) after 8 hours of food deprivation were administered orally with hard gelatin capsules containing dexamabinol of high enantiomeric purity at a dose of
10 40 mg/kg. Dexamabinol plasma levels were determined using a validated GC-MS assay up to 48 hours following administration. The results obtained showed about 12% oral bioavailability of dexamabinol compared to i.v. injection. Pharmacokinetic analysis was done using the non-compartmental model analysis (WinNonlin software). Linear trapezoidal rule was used to compute AUC and AUMC. The pharmacokinetic parameters for dexamabinol after oral
15 administration are summarized in Table 11.

Table 11. PK parameters of dexamabinol after oral administration.

Cmax (ng/ml)	t _{1/2} (hr)	AUC* (ng*min/ml)	MRT (hr)*	AUC/D (mg x min/ml)	% F
271.11 ± 101.84	7.47 ± 1.06	252,568.91 ± 72,387.35	12.06 ± 1.15	6,445.13 ± 1,846.93	12.13 ± 3.48

*Total body clearance for extravascular administration.

Rectal delivery

- The neuroprotectant drug dexamabinol was shown to have additional potent anti-inflammatory activity in several animal models. Dexamabinol has demonstrated beneficial effect in a murine model of inflammatory bowel disease (IBD). In chronic gastrointestinal (GI) diseases like IBD, ulcerative colitis or Crohn's disease where gastrointestinal damage exists, the rectal route is preferred for drug administration to avoid adverse effects and additional GI disturbances and to affect locally the seat of disease. A rectal formulation of enantiomerically pure dexamabinol, which can be administered either as an enema or suppository dosage forms, was developed. The composition of dexamabinol rectal formulation is shown in Table 12.

Table 12. Composition of dexamabinol rectal formulation.

Ingredient	% w/w
Dexamabinol of high enantiomeric purity	0.5%
Xantham gum (KELTROL® TF)	1.0%
Polyethyleneglycol 1000 (PEG 1000)	98.5%

PEG 1000 is an excipient extensively used in rectal preparations and suppository bases. Xantham gum is a high molecular weight, high viscosity polysaccharide particularly suitable for controlled release applications. The unique solution properties of xantham gum provide many

5 attractive features to pharmaceutical formulations to suspend and stabilize dispersions of solids and immiscible liquids in aqueous systems. Xantham gum provides excellent suspension and thickening properties at very low concentrations. It hydrates well in both acid and alkaline media and the viscosity is relatively unaffected by pH. KELTROL® TF dissolves in cold water at moderate concentrations to produce solutions of high viscosity. The high viscosity is often
10 useful for providing bioadhesiveness to mucosal surfaces. Bioadhesion to mucous membranes may also be improved by combining xantham gum with polyols. Thus, the combination of xantham gum with PEG 1000 provides an excellent vehicle for bioadhesion and sustained release of the active ingredient dexamabinol increasing its activity and prolonging its residence time in the site of action in the proximity of GI mucosal surfaces.

15 The PEG 1000 vehicle (USP/NF grade, Spectrum Quality Products, Inc.) was melted in a water bath at ~50°C. Dexamabinol of high enantiomeric purity was added to the melted PEG 1000 and mixed at ~50°C for about 2 hours until complete dispersion. The xantham gum (KELTROL® TF, Monsanto Pharmaceutical Ingredients) was then added and the mixture was shaken for another 1 hr at 50°C until a homogeneous dispersion is obtained. The final product
20 melts between 36-38°C, therefore it can be molded to obtain suppositories or it can be administered to animals rectally as an enema by melting it at 40°C to get a fluid and using a rectal catheter.

25 Previous animal studies using a murine IBD model demonstrated beneficial effect of dexamabinol administered intra peritoneously. The pharmacological activity of dexamabinol of high enantiomeric purity in enema formulation was also tested and compared to oral and i.p. formulations, wherein oral delivery was performed using a hard gelatin capsule and i.p. delivery was performed using the CREMOPHOR EL®:ethanol formulation. IBD was induced in Sprague Dawley male rats, by rectal administration of a 5% acetic acid solution. The rectum was then washed with saline and animals were clinically observed (body weight, stool consistency and

blood in stool) daily for 7 days. On the eighth day, the animals were sacrificed, their colon opened and gross pathology lesions were recorded (hyperemia, edema, number of erosions, ulcers, perforations and adhesions). Animals, at least six per group, were treated rectally (by enema) with either dexanabinol (5, 10, 20 or 40 mg/kg/day) or its vehicle or by oral gavage (20, 5 40, or 80 mg/kg/day or vehicle). Administration of acetic acid caused a decrease in body weight (up to 20%), changes in stool consistency (diarrhea) and appearance of blood in the stool 24 hours later. Spontaneous clinical healing was detected as animals regained weight and blood was no more evident in the stool. In the gross pathology scale, rectal dexanabinol 10 mg/kg had the best effect (more than 50% reduction of score) compared to its vehicle ($p<0.05$). Dexanabinol 10 10 mg/kg reduced also the clinical disease severity compared to the vehicle. The rectal dexanabinol dose of 10 mg/kg was pharmacologically equivalent to 20 mg/kg i.p. dose and 80 mg/kg oral dose. The results of the present work demonstrate the beneficial effects of dexanabinol enema formulation in IBD murine model.

Topical delivery

15 The ocular hypotensive effect of cannabinoids intrigued clinicians and investigators alike to exploit these compounds as anti-glaucoma drugs. Nevertheless, the psychotropic effects of these compounds prohibited such large-scale attempts. Ocular hypotensive effect in the rabbit is sometimes difficult to detect due to large intrinsic variations of intra-ocular pressure (IOP) irrespective of the investigated drug. Rabbits were acclimatized for at least a week prior to 20 experiments in the animal facility and their IOP were measured repeatedly prior to data collection. Taking these precautions it was possible to repeatedly demonstrate IOP lowering effect of dexanabinol of high enantiomeric purity upon topical administration in normotensive rabbits.

Dexanabinol was formulated either in submicron emulsion (SME) or in hydroxypropyl-
25 cyclodextrin (HPCD). The solutions of dexanabinol in HPCD were prepared as follows. First, a weighted amount of dexanabinol was dissolved in a minimum amount of absolute ethanol. The drug containing ethanol solution is then added dropwise to the HPCD powder, which is subsequently dried at 48-80°C until ethanol evaporates. Water is then added and mixed with the dried powder to give final dexanabinol concentrations of 0.1 to 2 mg/ml and HPCD 30 concentrations of 5 to 45%. Complete dissolution is obtained by sonication and heating. The homogenous solutions are then filtered through 0.2-0.45 µm sterile disposable filter unit.

Submicron emulsions are made of homogenous oily droplets in a size range of 50-80 nm emulsified in aqueous solution. Various ocular drugs, including timolol, pilocarpine and indomethacin were successfully formulated in SME and were advantageous over the standard

formulations both in terms of irritation and bioavailability. The composition of dexanabinol topical formulation is shown in Table 13.

Table 13. Dexanabinol formulation in SME.

Phase	Ingredient	% w/v
Oil	MCT Oil	4.25%
	Lecithin (LIPOID E-80®)	0.75%
	DL- α -Tocopherol Succinate	0.02%
	Dexanabinol	0.1%
Water	Polysorbate 80	1.0%
	Glycerol	to 300 mOsm (~2.25%)
	EDTA	0.1%
	Benzalkonium Chloride	0.01%
	Purified water	to 100%

A total volume of about 100 ml (100 g w/w%) of dexanabinol in SME was prepared. The oil phase stock was composed of Medium-chain triglyceride (MCT) Oil, LIPOID E-80® and DL- α -Tocopherol Succinate and dexanabinol of high enantiomeric purity. The lipids and oil were weighed in a 250 ml beaker and mixed at 40-45°C using a magnetic stirrer for 15 min until a homogenous and almost clear solution was obtained. Dexanabinol was then dissolved in the oil phase by stirring at room temperature (RT). The water phase was prepared as follows. Polysorbate 80, EDTA disodium, glycerol, and benzalkonium chloride were dissolved at RT in purified water up to a final weight of 100 g in 250 ml beaker by gentle shaking using the magnetic stirrer plate until a clear homogenous solution was obtained. The gentle stirring is aimed to avoid the formation of bubbles in the solution. Each material is dissolved in the water separately, in the specified order of addition.

Once both phases are ready they are mixed according to the following procedure. Oil Phase (5 g) was heated to 40-45°C and added to the beaker containing the water phase (preheated to 40-45°C). The mixture was gently stirred for 10-15 minutes at room temperature. First a coarse Oil-in-Water emulsion is prepared, using the medium-sized dispenser and homogenizing unit Polytron PT3000 at 12,000 rpm for 3 minutes. The temperature during the Polytron step should be in the range of 25-45°C. The resultant micron size emulsion was cooled at room temperature. The droplet size of the emulsion obtained after Polytron step was lowered to the submicron (nanosize) range by submitting the emulsion to high shear homogenization using the Gaulin Microlab 70 or Emulsiflex High Pressure Homogenizers at 800 bar pressure. A

total of 3 to 6 cycles were performed to obtain homogeneous SME preparation with a mean droplet diameter in the range of 50-100 nm. The pH of the resultant SME was adjusted to 7.4 by adding small amounts of 1 N HCl or 1 N NaOH solutions using a calibrated pH meter. The osmolalities of all SME obtained were around 300 mOsm. If the value obtained is below 300 ± 5 mOsm it must be adjusted by adding Glycerol. The SME formulations were sterilized by filtration through a 0.2 µm sterile disposable filter unit (cellulose acetate, 0.5 liter volume, Corning, England), using vacuum supplied by water pump. The SME formulations were packaged under aseptic conditions in 5 ml plastic droppers in laminar flow hood using sterile (by gamma irradiation) low density polyethylene (LDPE) eye drop bottles, insert and caps. This 10 dexamabinol SME formulation was then tested in normotensive rabbits.

New Zealand White albino rabbits weighing 2-2.5 kg were acclimatized in our animal facility for at least a week prior to IOP measurements. Drug, saline and blank-vehicle groups (n=8-12 animals per group) were included. In most experiments, 50 µl drops were applied at 09:00 and measurements were taken 1 hour, 3, 5, and 7 hours later. Baseline IOP was 15 individualized for each animal and time point prior to drug testing. IOP was measured by a Digilab Pneumatonometer, Model 30R. ΔIOP was calculated by subtracting the baseline IOP from IOP value measured after drug application at a corresponding time point. Maximal ΔIOP and area under the ΔIOP x hours curve (AUC) were calculated and averaged for each group. Data of IOP, AUC, blood pressure and toxicity were analyzed by the Wilcoxon-Rank test.

Average values of maximal ΔIOP after topical instillation of dexamabinol of high enantiomeric purity varied between 7.0 mmHg to 1.6 mmHg in several experiments with a range of dosages and formulations. IOP was reduced in dexamabinol treated groups compared to blank-vehicle and saline groups in virtually all our experiments. The blank SME vehicle was devoid of any significant IOP lowering activity as compared to saline treatment. In one study, groups of 25 rabbits (n=8, each) were followed for three days with a daily application of dexamabinol of high enantiomeric purity and demonstrated a sustained IOP lowering effect over that time period.

Dose dependency was studied using 0.02%; 0.05%; 0.1%; 0.2% dexamabinol; vehicle and saline control groups in a masked study. A small, yet statistically significant ($p<0.05$) IOP lowering effect of all doses of dexamabinol of high enantiomeric purity compared to the vehicle 30 and the saline was demonstrated. The most effective dose was 0.1% ($AUC=14.6\pm2.2 \text{ mmHg} \times \text{Hour}\pm\text{SEM}$; Maximal ΔIOP= $2.9\pm0.4 \text{ mmHg}$). Other dosages of 0.02%; 0.05% and 0.2% were significantly less effective with $AUC=6.4\pm2.5$; 5.1 ± 3.7 and $6.9\pm1.7 \text{ mmHg} \times \text{Hour}$, respectively and maximal ΔIOP of $1.8\pm0.7 \text{ mmHg}$; 1.8 ± 0.9 ; and 2.2 ± 0.6 , respectively. Similar AUC values were found by us for other commercially available drugs: Timolol (Merck Sharp & Dohme) and

levobunolol HCl (Allergan) yielded 7.3 ± 3.0 and 13.3 ± 1.5 mmHg x Hours respectively.

Ocular toxicity was tested as follows. Two groups of five animals each received topical instillation of dexanabinol in SME and blank SME for five days four times daily. The animals were examined daily with a slit lamp for ocular discharge, conjunctival hyperemia, corneal fluorescein staining and iris hyperemia. Results were scored on a 0.0-4.0 scale in 0.5 steps. Topical treatment with dexanabinol of high enantiomeric purity resulted in mild conjunctival injection and discharge that did not significantly differ from SME-blank treated animals. Corneal staining, corneal opacities and iris hyperemia did not occur in any of the animals.

Dose dependency and a clear effect on aqueous humor dynamics were shown for topical administration. In this model, it was possible to demonstrate that topical application of dexanabinol is non psychotropic and has none of the ocular adverse effects typical to other cannabinoids Our data suggest that these investigations of dexanabinol of high enantiomeric purity for the therapy of glaucoma may yield a new generation of anti-glaucoma drugs with both IOP lowering and neuroprotective effects. The retino-neuroprotective effect of dexanabinol of high enantiomeric purity is currently studied on ischemic retina in rabbits. Such neuroprotective effect may prove to be critically important in preserving ganglion fibers in glaucomatous damaged optic nerves.

Example 7.

Formulations for a water-soluble hemisuccinate ester of dexanabinol.

As already stated, dexanabinol is highly insoluble in water, thus attempts were made to increase its solubility by means of chemical modification including the preparations of salts and esters. Dexanabinol hemisuccinate is one of the dexanabinol derivatives with significantly increased water solubility, 17,000 fold higher. The same criterion of enantiomeric purity applies not only to the dexanabinol molecule but also to its pharmaceutically acceptable salts or esters derivatives. Following are examples of formulations appropriate for the water-soluble derivatives of dexanabinol of high enantiomeric purity.

Thirty milligrams of dexanabinol hemisuccinate were dissolved in 0.3 ml tert-butanol. To obtain a final 5 mg/ml drug concentration, 6 ml of phosphate buffer (KH_2PO_4 and Na_2HPO_4 , pH 7-8, 80 mM or 18 mg/ml) were added. Then 150 mg lactose were added to get a final lactose concentration of 25 mg/ml. The resulting solution was freeze-dried overnight to get a lyophilized powder. The lyophilized powder of dexanabinol hemisuccinate was later reconstituted with water to get a clear solution of the ester derivative in the range of 2-8 mg/ml final concentration, which is a dramatic increase in solubility as compared to the initial 0.1 ng/ml of the dexanabinol parent drug. The same formulation was also prepared containing, in addition

to the phosphate buffer, benzyl alcohol at a concentration of 9 mg/ml. Sucrose 5%, or mannitol 5%, or glycerol 2%, or dextran 5%, or polyvinylpyrrolidone (PVP) K-30 2%, or PVP K-10 2% can be added instead of lactose as diluent and cryoprotectants during the freeze-drying process.

The lyophilized dexanabinol hemisuccinate was successfully reconstituted in various aqueous solutions, two of them corresponding to 0.5% and 1.0 % dexanabinol equivalents. The composition of the reconstituted dexanabinol hemisuccinate aqueous solutions is given in Table 14. The concentrations are given as weight per volume.

Table 14. Reconstituted dexanabinol hemisuccinate aqueous solutions.

Substance	Formulation 1	Formulation 2
Dexanabinol hemisuccinate dry	1.26 %	0.63 %
Polyvinylpyrrolidone K12	2.0 %	2.0 %
Na_2HPO_4	0.3 %	0.3 %
NaH_2PO_4	0.1 %	0.1 %
Ascorbic acid	0.02 %	0.02 %
EDTA disodium dihydrate	0.05 %	0.05 %
Sodium metabisulfite	0.02 %	0.02 %
Mannitol	2.2 %	2.2 %
Sodium hydroxide	to pH 7.2±0.1	to pH 7.2±0.1

The procedure is as follows: First, prepare the buffer. Place dry phosphate salts, PVP, mannitol, ascorbic acid, EDTA and sodium metabisulfite into suitable container and add necessary volume of pure water. Stir on magnetic stirrer until complete dissolution. Adjust pH to 7.8±0.1 by adding 2 N NaOH and filtrate the resulting buffer through 0.2 μm Teflon membrane PTFE filter. Then add the filtered phosphate buffer with PVP and additives to a weighed flask with a known amount of dry dexanabinol hemisuccinate free acid to obtain final concentration of dexanabinol hemisuccinate of 1.26 % w/v (equivalent to 1.0 % dexanabinol). Shake or stir intensively until complete dissolution. Every 0.5 hours pH must be tested and adjusted, if necessary, to 7.2±0.2 by addition of 2 N NaOH. After complete dissolution, the transparent solution is transferred to a beaker, pH adjusted to 7.2±0.2 by addition of 2 N NaOH. To obtain the 0.63 % w/v solution of dexanabinol hemisuccinate (equivalent to 0.5 % dexanabinol) one volume of the 1.26 % solution is mixed with an equal volume of the phosphate PVP buffer. The pH is tested and adjusted, if necessary. Ready solutions are filtered through sterile 0.2 μm PTFE or nylon membrane filter and packed in the sterile Type I glass bottles (1, 2 or 5 ml in one bottle), sealed with butyl rubber stoppers.

Altogether these studies show that dexanabinol of high enantiomeric purity, or its pharmaceutically acceptable salts or esters derivatives, can be prepared in various types of formulations and administered by various routes of administration to treat the diseases induced in the models above-described.

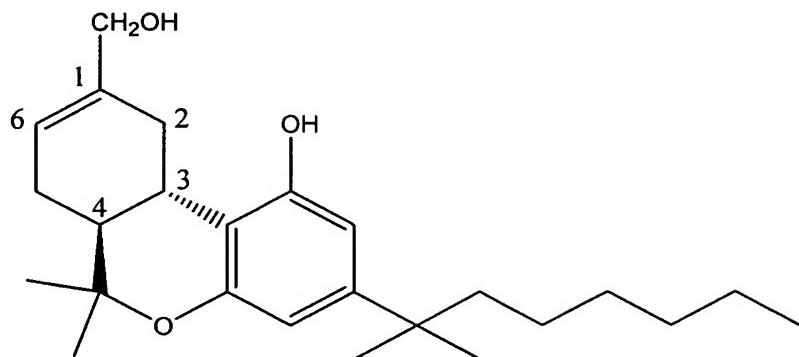
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Although the present invention has been described with respect to various specific embodiments presented thereof for the sake of illustration only, such specifically disclosed embodiments should not be considered limiting. Many other such embodiments will occur to those skilled in the art based upon applicants' disclosure herein, and applicants propose to be
10 bound only by the spirit and scope of their invention as defined in the appended claims.

CLAIMS

1. A compound of formula (I):

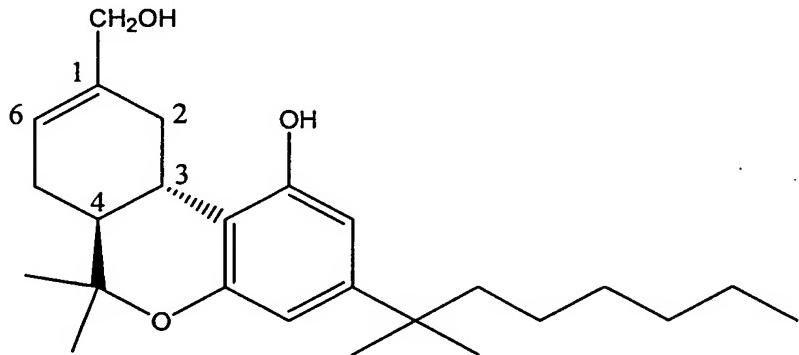
Formula I



5 having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over
the (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said
compound.

2. The compound of claim 1 or a pharmaceutically acceptable salt, ester or solvate of said
compound, having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least
10 99.92% over the (3*R*,4*R*) enantiomer.
3. The compound of claim 2 or a pharmaceutically acceptable salt, ester or solvate of said
compound, having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least
99.95% over the (3*R*,4*R*) enantiomer.
4. A pharmaceutical composition comprising as an active ingredient dexamabinol, a
15 compound of formula (I):

Formula I

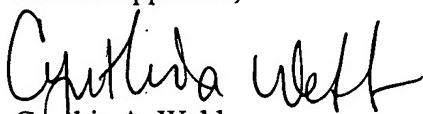


- having the (3*S*,4*S*) configuration and being in enantiomeric excess of at least 99.90% over the (3*R*,4*R*) enantiomer, or a pharmaceutically acceptable salt, ester or solvate of said compound.
5. The pharmaceutical composition according to claim 4 wherein the active ingredient dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, has the (3*S*,4*S*) configuration and is in enantiomeric excess of at least 99.92% over the (3*R*,4*R*) enantiomer.
10. The pharmaceutical composition according to claim 5 wherein the active ingredient dexanabinol, or a pharmaceutically acceptable salt, ester or solvate of said compound, has the (3*S*,4*S*) configuration and is in enantiomeric excess of at least 99.95% over the (3*R*,4*R*) enantiomer.
15. The pharmaceutical composition according to any one of claims 4 to 6 further comprising a pharmaceutically acceptable diluent or carrier.
8. The pharmaceutical composition according to claim 7 wherein the diluent comprises an aqueous cosolvent solution comprising a pharmaceutically acceptable cosolvent, a micellar solution or emulsion prepared with natural or synthetic ionic or non-ionic surfactants, or a combination of such cosolvent and micellar or emulsion solutions.
20. 10. The pharmaceutical composition according to claim 7 wherein the carrier comprises a solution of ethanol, a surfactant and water.
11. The pharmaceutical composition according to claim 7 comprising a cosolvent solution comprising polyoxyl 35 castor oil and ethanol.
25. 12. The pharmaceutical composition according to claim 11 comprising polyoxyl 35 castor oil 30-80% w/w and ethanol 20-70% w/w.
13. The pharmaceutical composition according to claim 12 comprising polyoxyl 35 castor oil 45-80% w/w and ethanol 20-55% w/w.
14. The pharmaceutical composition according to claim 13 comprising polyoxyl 35 castor oil 60-80% w/w and ethanol 20-40% w/w.

15. The pharmaceutical composition according to any one of claims 11 to 14 further comprising a preservative, an antioxidant or a combination of such agents.
16. The pharmaceutical composition according to claim 15 wherein the antioxidant is DL- α -tocopherol optionally supplemented with Edetic acid.
- 5 17. The pharmaceutical composition according to claim 15 comprising DL- α -tocopherol 0.1-5% w/w and Edetic acid 0.001-0.1% w/w.
18. The pharmaceutical composition according to any one of claims 4 to 17 in unit dosage form.
19. The pharmaceutical composition according to claim 18 suitable for oral administration.
- 10 20. The pharmaceutical composition according to claim 18 suitable for parenteral administration.
21. A method for preventing, alleviating or treating neurological disorders, chronic degenerative diseases, CNS poisoning, post-operative cognitive impairment, inflammatory diseases or disorders, autoimmune diseases or disorders, pain, emesis, glaucoma and wasting syndromes, by administering to an individual in need thereof of a prophylactically and/or therapeutically effective amount of a pharmaceutical composition comprising as an active ingredient a compound according to any one of claims 1 to 3.
- 15
22. Use for the manufacture of a medicament for preventing, alleviating or treating neurological disorders, chronic degenerative diseases, CNS poisoning, post-operative cognitive impairment, inflammatory diseases or disorders, autoimmune diseases or disorders, pain, emesis, glaucoma and wasting syndromes, of a compound according to any one of claims 1 to 3.
- 20

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For the Applicant,


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ABSTRACT

The present invention relates to a synthetic cannabinoid, dexanabinol, of high enantiomeric purity, or to a pharmaceutically acceptable salt, ester or solvate of said compound. The present invention also relates to pharmaceutical grade compositions comprising said compound of high 5 enantiomeric purity, and uses thereof for prevention and treatment of neurological disorders, chronic degenerative diseases, CNS poisoning, post-operative cognitive impairment, inflammatory diseases or disorders, autoimmune diseases or disorders, pain, emesis, glaucoma and wasting syndromes.

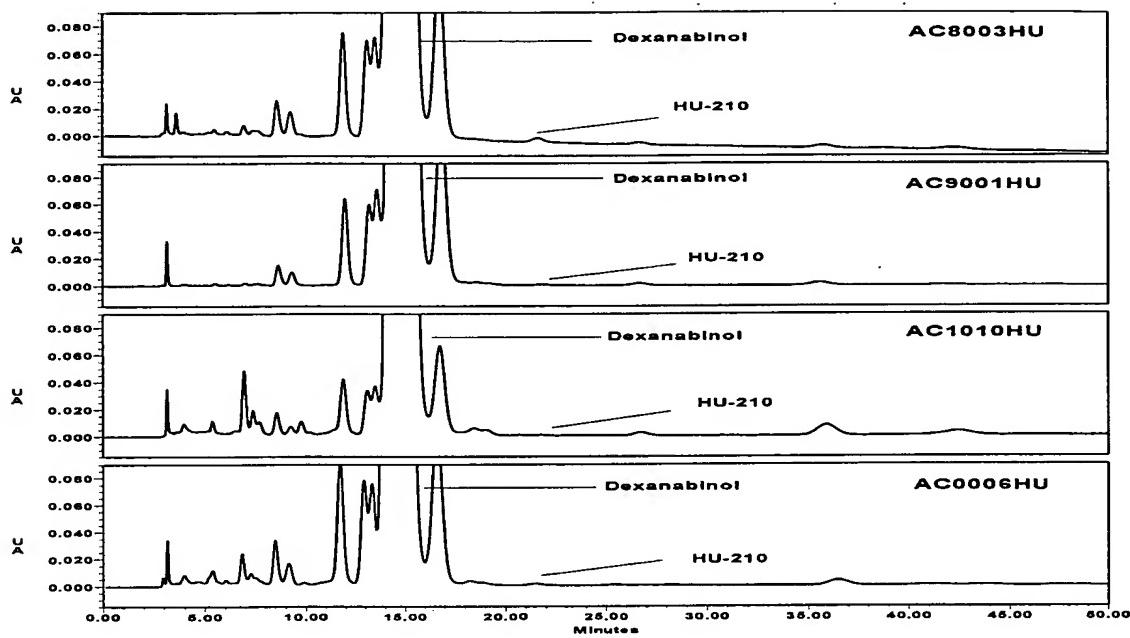
Figure 1

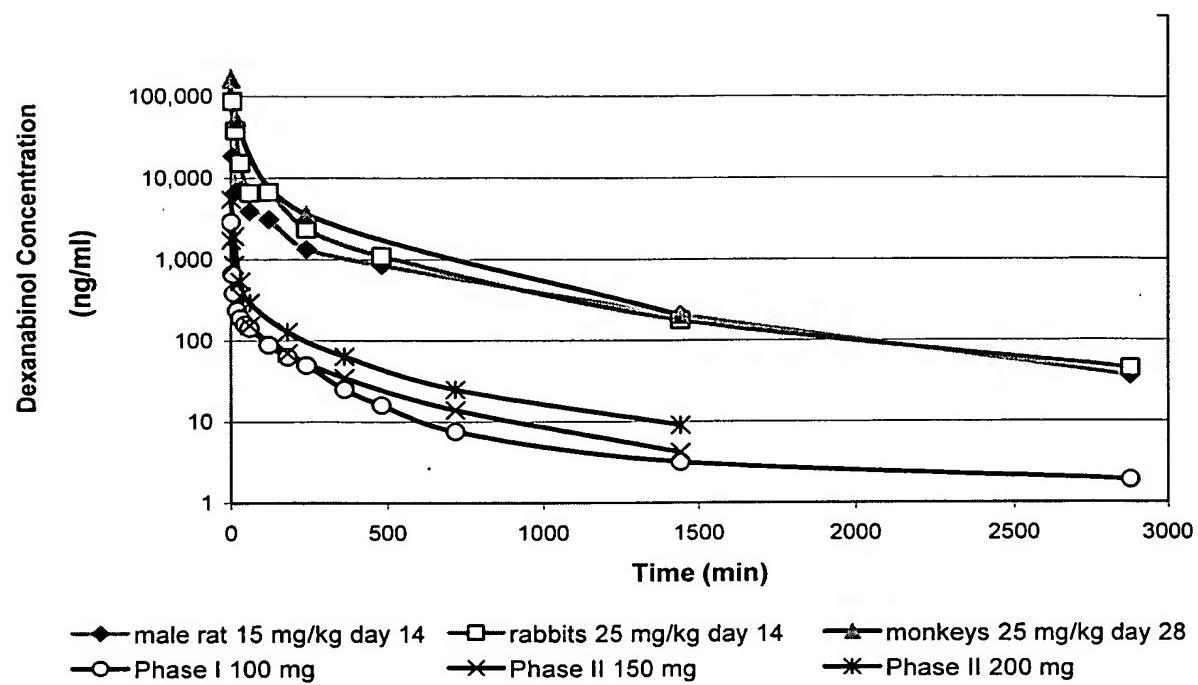
Figure 2

Figure 3